BASIN IMMEDIATE CARE

Patient Registration

ACCT#

For Office use

Patient Information

Today's Date: _____

Patient's SSN: ____ - ____ - ____

Patient First Name: _____ Middle Initial: _____ Last: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home #: ( ) ____ - ____ Cell #: ( ) ____ - ____ Email: _____ (gives BIC permission to send to this address)

DOB: ____ / ____ / ____ Age: ____ Preferred Language: _____

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner

Medicines or Substances to which Patient is allergic: _____

Personal MD: _____ Phone#: ( ) ____ - ____

Patient Employer Name: _____ Work #: ( ) ____ - ____ ext: ____

Employer Address: _____ City: _____ State: _____ Zip: _____

Is this an on-the-job injury? ☐ **Yes** ☐ **No**

Emergency Contact: _____ Phone #: ( ) ____ - ____ Relationship: _____

Information Release

How would you like us to contact you for follow up calls and/or lab results? ☐ Phone (OK to leave a message) ☐ Mail

In order to share any of your medical and/or account information with another person, you must write their name and relationship below. Without this authorization, Basin Immediate Care will **NOT** release any of your medical and/or account information. **You may revoke this release at any time.**

Name/Phone#/Relationship (spouse, parent, etc.)

Release Medical Info to: _____ Release Account/Financial Info to: _____

Contact Phone #: ( ) ____ - ____ Contact Phone #: ( ) ____ - ____

Guarantor Information (Responsible Party)

If Patient and guarantor are the same, please check here ☐ Relationship to patient: _____

First Name: _____ Middle Initial: _____ Last: _____

Guarantor SSN: ____ - ____ - ____ Guarantor's DOB: ____ / ____ / ____

Address (if different from patient) _____ City: _____ State: _____ Zip: _____

Phone #: ( ) ____ - ____ Employed by: _____ Work Phone #: ( ) ____ - ____

Insurance Information

Primary Insurance Company: _____ Group #: _____ Policy/ID #: _____

Subscriber Name: _____ Subscriber DOB: ____ / ____ / ____ Subscriber SSN: ____ - ____ - ____

Employer Name: _____

Secondary Insurance Company: _____ Group #: _____ Policy/ID #: _____

Subscriber Name: _____ Subscriber DOB: ____ / ____ / ____ Subscriber SSN: ____ - ____ - ____

Employer Name: _____