# REGISTRATION FORM

*Please complete **ALL** information on the form*

## PATIENT REGISTRATION INFORMATION

| | | | |
|---|---|---|---|
| Last Name | | First Name | |
| Middle Name | | Ethnicity | |
| SS# | | Sex | ☐ Male ☐ Female |
| D.O.B | | Status ☐ Married ☐ Single ☐ Widow(er) ☐ Minor | |
| Address | | | |

| | | | | | |
|---|---|---|---|---|---|
| City | | State | | Zip Code | |
| Home # | | Cell # | | Email | |

| | | | |
|---|---|---|---|
| Place of Employment | | Occupation/Title | |

## EMERGENCY CONTACT INFORMATION

| | |
|---|---|
| Emergency Contact Name | |
| Relationship to Patient | |
| Emergency Contact # | |

## PRIMARY INSURANCE INFORMATION/RESPONSIBLE PARTY/POLICY HOLDER

| | |
|---|---|
| Relationship to Patient | ☐ Self ☐ Mother ☐ Father ☐ Other (specify) |

| | | | | | |
|---|---|---|---|---|---|
| Last Name | | First Name | | MI | |
| SS# | | Sex | ☐ M ☐ F | D.O.B (Policy Holder) | |

| | |
|---|---|
| Policy Holder Address (if other than listed above) | |
| Email | |

| | | | |
|---|---|---|---|
| Insurance Company | | Member ID | |
| Group Name | | Group Number | |

## PREFERRED PHARMACY

| | | | |
|---|---|---|---|
| Pharmacy Name | | Pharmacy Phone # | |

**Last Name**________________________**First Name**________________________**MI** ______ **DOB**____________

**CHIEF COMPLAINT: What is the primary reason for your visit today?**
_____________________________________________________________________________________________________

**Primary Care Physician Name** _______________________________ **Phone #** _____________________________________

**Allergies** _______________________________________________

**List Current Medications if any** ___________________________________________________________________________

## Consent for Treatment

Patient authorizes and consent to AnytimeMD Urgent Care to Treat/Provide services as deemed necessary and appropriate by the providers or others health care professionals at ANYTIME MD URGENT CARE. Medical Treatment/Services may be performed by "Healthcare Professionals" (i.e. Physician, Advanced Nurse Practitioner, Physician Assistants and Medical Technician/Assistance etc.). The consent to receive "Medical Treatment/Services" includes, but is not limited to: urgent care; examinations (i.e. X-Ray); laboratory procedures; medications; minor surgical treatment or procedures and other services which Patient may receive. I acknowledge that If the provider has ordered additional laboratory testing, the collected specimens will be sent to a local laboratory for testing; you will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory.

### Financial Responsibility

I understand it is the responsibility of each patient to arrange for payment for the medical services received at Anytime MD Urgent Care. I hereby authorize any insurance benefits to be paid directly to AnytimeMD Urgent Care, and recognize my responsibility to pay for all non-covered services before or at the completion of rendered services. Insurance verification will be performed at the time of service; I authorize and direct AnytimeMD Urgent Care, having treated me, to release any information necessary to process an insurance claim or to others who are financially liable for my care. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

### Acknowledgement of Privacy Rights

By signing below, I acknowledge that I have received the AnytimeMD Urgent Care notice of Privacy Practices and Individual Rights.

### Release of Medical Information & Records Consent

AnytimeMD Urgent Care may want to contact you by phone or email with Protected Health Information i.e. Lab results. We can leave detailed Protected Health Information with your Consent.

Phone __________________________________ Cell /Home; I do not consent ☐

Email ________________________________________; I do not Consent ☐

By signing below, I acknowledge that I have received the AnytimeMD Urgent care notice of Privacy Practices and Rights. I acknowledge that I have carefully read the above and am giving my consent to the above.

Signature_______________________________________ Date ________________

Name __________________________________________