PATIENT REGISTRATION

Date: _____

Type of Visit: ☐ Urgent Care – Chief Complaint/Symptoms: _____

☐ Worker's Compensation – Injury: _____

☐ K-12 Sports/School PE ☐ College - Adult Sports/School PE ☐ Wellness Exam

☐ Pre-Employment Physical ☐ DOT Medical Exam ☐ Drug Screening

☐ Other *(Please explain)* _____

Patient

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____/_____/_____ SSN: _____/_____/_____

Sex: _____ Marital Status: _____

Address: _____ Primary Phone: _____

City: _____ Secondary Phone: _____

State: _____ Zip Code: _____

Would you like to receive emails from us? Y N Email Address: _____

Employer Name/Phone: _____

Race

□ White □ Black or African American □ Asian

□ American Indian or Alaska Native □ Native Hawaiian or Other Pacific Islander □ Hispanic or Latino

Preferred Language: _____ Do You Need Translation: Y N

Responsible Party

**Not Required if 18 or over*

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____/_____/_____ SSN: _____/_____/_____

Sex: _____ Marital Status: _____ Relationship to Patient: _____

Address: _____ □ Home Phone: _____

City: _____ □ Cell Phone: _____

State: _____ Zip Code: _____ □ Work Phone: _____

Employer Name/Phone: _____

In Case of Emergency

Last Name: _____ First Name: _____ Middle Initial: ____

Address: _____ Primary Phone: _____

City: _____ Secondary Phone: _____

State: _____ Zip Code: _____ Relationship to Patient: _____

Health Insurance

Primary Insurance: _____

Member ID: _____

Group #: _____ Effective Date: ___/___/___

Policy Holder's Name: _____

Date of Birth: _____/_____/_____

SSN: _____/_____/_____

Employer: _____

Relationship to Patient: _____

Secondary Insurance: _____

Member ID: _____

Group #: _____ Effective Date: ___/___/___

Policy Holder's Name: _____

Date of Birth: _____/_____/_____

SSN: _____/_____/_____

Employer: _____

Relationship to Patient: _____

Please complete your registration on the back of this form

PATIENT REGISTRATION (Continued)

Primary Physician	Primary Care Physician: _____ City: _____ Phone: _____
Medications	Please list all medications (with their dosage) that you are currently taking, including over the counter: *If you carry a list with you, please allow the registrar to make a copy for our records.* _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Please list any allergies to medications you have: _____ _____ _____ _____ _____ _____

Who referred you to us: _____

How did you hear about us? □ Billboard □ Doctor □ Drive by □ Friend/Relative □ Internet/Web Page
□ Work □ Other _____

I, the undersigned, hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary for payment and to obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf and I assign benefits to which I am entitled to this practice.
I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE *AND THAT* ***I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE.***

I hereby agree, that in the event of default in the payment of any amount due, and if this account is placed with a collection agency, for collection or any subsequent legal action, to pay an additional collection fee of 25% of the account balance due, as well as any attorney fees and court costs incurred and permitted by laws governing these transactions.

I expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, WellFast Urgent Care Center, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Photocopy of this agreement shall be as valid as the original.

x_____ _____
PRINT Patient Name Patient Signature

x_____ _____
PRINT Authorized Person Name / Relationship Authorized Person Signature

x_____
Date