



# EXCEL Urgent Care

## PATIENT REGISTRATION FORM

Reason for today's visit: \_\_\_\_\_

**Was this a result of a Motor Vehicle Accident?**  Yes  No Date of Accident: \_\_\_\_\_

**Was this a result of a Job Injury?**  Yes  No Date of Injury: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Sex:  Male  Female

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Current Street Address: \_\_\_\_\_ Apt#/Floor/Suite#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Best form of contact?  Home  Cell E-Mail Address: \_\_\_\_\_

Preferred Pharmacy (name and street): \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**Primary Care Provider:** \_\_\_\_\_

### Emergency Contact Info

Name: \_\_\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Relationship to patient: \_\_\_\_\_

### For any patient under the age of 18, please fill out this section:

Responsible Party (of the patient) Name: \_\_\_\_\_

\_\_\_\_\_ Sex:  Male  Female

Current Street Address: \_\_\_\_\_ Apt#/Floor/Suite#: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

### Primary Insurance

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Relationship to Subscriber \_\_\_\_\_

### Secondary Insurance

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Relationship to Subscriber \_\_\_\_\_



**AUTHORIZATION AND RELEASE**

**Authorization for Treatment:** I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent.

**Authorization for use of e-mail/cell phone:** I voluntarily consent to the use of my personal e-mail and/or cellular phone via voice or text to receive newsletters or notifications. This is NOT to be used for my private medical records or health information.

**Assignment of Insurance Benefits:** I authorize payment directly to EXCEL URGENT CARE OF FISHKILL for all benefits otherwise payable to me.

**Guarantee of Payment:** I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co pays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

**Release of Records:** I authorize EXCEL URGENT CARE OF FISHKILL to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow up purposes.

**Receipt of Privacy Practices:** I acknowledge that I have received and read the Notice of Privacy Practices of EXCEL URGENT CARE OF FISHKILL I understand that a copy of this agreement may be used with the same effectiveness as the original.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**CONSENT FOR NOTIFICATION OF TEST RESULTS/MEDICAL INFORMATION**

**I give permission to EXCEL URGENT CARE OF FISHKILL to:**

1. Follow- up phone calls or call backs in regards to care at Excel Urgent Care using this phone #: \_\_\_\_\_
2. Leave message on my answering machine: **(circle one)** Yes/No
3. Discuss my health information with the following people \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_