PrimeCare
URGENT & FAMILY CARE

PATIENT REGISTRATION

Reason for Today's Visit _____

Last Name_____ First Name_____ MI_____

Social Security #_____ Date of Birth_____ ☐ Male ☐ Female

Street Address_____ City_____ State_____ Zip_____

Home #_____ Cell # _____ Work # _____

I give permission to leave a detailed message including results at the following numbers ☐ Home ☐ Cell ☐ Work

E-mail _____ Are you interested in our Patient Portal? ☐ Yes ☐ No

Primary Care Physician_____ Preferred Pharmacy_____

How did you hear about PrimeCare? _____

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

List names of those authorized to receive your PHI and their relationship to you. We will **not** discuss your PHI with anyone who is **not** listed by name on this form. Please include spouse, parent/legal guardian names, as applicable.

1. I authorize you to speak to_____ Relationship_____
2. I authorize you to speak to_____ Relationship_____
3. I authorize you to speak to_____ Relationship_____

GUARANTOR/RESPONSIBLE PARTY INFORMATION

(Complete only if patient is not financially responsible, i.e. minor child)

Guarantor Name _____ Relationship to Patient ☐ Parent ☐ Legal Guardian

Guarantor Date of Birth_____ Guarantor SSN_____

Street Address_____ City_____ State_____ Zip_____

INSURANCE INFORMATION

Primary Plan Name _____

Policyholder Name _____ Policyholder Date of Birth_____

Policyholder SSN _____ Policyholder Relationship_____

Secondary Plan Name _____

Policyholder Name _____ Policyholder Date of Birth_____

Policyholder SSN _____ Policyholder Relationship_____

Patient/Guarantor Signature_____ Date_____