Great Lakes Urgent Care Center, PC

PATIENT REGISTRATION

Name: ______________________________ SS#: ______________

First Middle Last Birthdate: ______________

Address: ______________________________ Phone: ( ) ______________

City: __________ State: ________ Zip Code: __________ Mobile: ( ) ______________

Sex: ____M ____F Marital Status: ____S ____M ____D ____W Email: ______________

Employer: ______________ Occupation: ______________ Years There: ________

Employer's Address: ______________________________ Work Phone: ( ) ______________

City: __________ State: ________ Zip Code: __________

Spouse/Legal Guardian:

Name: ______________________________ Relationship: ______________

First Middle Last SS#: __________ Birthdate: __________

Address: ______________________________ Phone: ( ) ______________

City: __________ State: ________ Zip Code: __________ Work Phone: ( ) ______________

Nearest Relative/Emergency Contact (Not Residing at the Same Address):

Name: ______________________________ Relationship: ______________

First Middle Last Phone: ( ) ______________

Address: ______________________________ Work Phone: ( ) ______________

City: __________ State: ________ Zip Code: __________

Other Information: ______________________________

I hereby voluntarily request, consent to, and authorize Great Lakes Urgent Care Center PC to provide medical and minor surgical treatments. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examination and treatment which I have hereby authorized.

I authorize Great Lakes Urgent Care Center PC to release any medical information necessary to process insurance claims. I also authorize payment of medical and surgical benefits to Great Lakes Urgent Care Center PC.

I authorize Great Lakes Urgent Care Center PC to release a copy of my treatment today to my Primary Care Provider. I assume full financial responsibility for payment of all services provided to me, including any portion of my bill that is not paid by my insurance(s), workers' disability compensation, or social agencies.

I acknowledge that I have received or have been offered a copy of this office's ***Notice of Privacy Practices Form*** *.*

I understand the content and significance of this form, and my questions have been answered.

______________________________ ______________

Patient/Legal Guardian Signature (Relationship) Date

______________________________ ______________

Witness Signature Date