NEW PATIENT REGISTRATION FORM
NEW

PATIENT INFORMATION **Reason for Visit**___________________________________

Patient's Full Name Ethnicity: Caucasian __African American __Asian __Pacific Islander__ Native American __Hispanic/Latino__

Last Name ________________________ **First Name** __________________**MI** _____ Age _______

Social Security # _________ - _______ - _________ Date of Birth __MM/__DD/__YYYY Sex: ☐ Male ☐ Female

Mailing Address____ Apt/Unit________City____________________ State ______ Zip Code________

Cell phone: (______) ________-__________ Alternate phone number (_____) ________-__________ Email_______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Spouse's Name ____________________________________

Emergency Contact Name ____________________________________ Telephone Number (______) __________-___________Relation:_____________

Primary Care Physician ______________________________________ Telephone Number (______) __________-____________

Primary Insurance__________________________________ Policy Holder____

*Policy Holder: Date of Birth*__________________ *Social Security #*________________________ *Relationship to Patient*_______________

Secondary Insurance________________________________ *Policy Holder*____

*Policy Holder: Date of Birth*__________________ *Social Security #*________________________ *Relationship to Patient*________________

*** Is Patient under 18 years of age** ☐ Yes ☐ No (If yes, please complete below)

Parent/Guarantor Name ____ Relationship to Patient ______________________________

Mailing Address (only if different from patient address) ____

City____________________________ State _______ Zip Code_________ Telephone Number (_____) ______-__________

How did you hear about us? __________________________ Preferred Pharmacy____

☐ Check to opt out of marketing communication

CONSENT FOR MEDICAL TREATMENT

I hereby consent to the procedures which may be performed during this examination, including services which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, and/or surgical treatments or procedures, anesthesia or other urgent services rendered to me under the general and special instruction of a Duke City Urgent Care Provider.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the notice of privacy practices, which describes the ways in which Duke City Urgent Care may use and disclose my healthcare information for treatment, payment of services, healthcare operations and other described and permitted uses and disclosures.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the payment directly to Duke City Urgent Care, LLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for any and all charges not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further acknowledge that I have received and read the financial policy for Duke City Urgent Care. I understand and agree to the financial policy.

FINANCIAL AGREEMENT

In consideration of the services rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, and agent or as the patient) individually promises to pay the patient's account at the rates established by the clinic for services provided. A receipt of charges for services to the patient is available upon request. All final charges are based on multiple factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

I hereby consent, acknowledge and fully understand the above. I also understand there are no guarantees or assurances from anyone as to the results that may be obtained from any medical treatment or services rendered at Duke City Urgent Care.

Signature of Patient/Guarantor: ____ Date: ______________________

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For office use only

Documentation of Good Faith Efforts

To obtain patient's acknowledgement that they received provider's Notice of Privacy Practices

For use when acknowledgement cannot be obtained from the patient.

The patient presented to the clinic on ________________________________and was provided with a copy of Duke City Urgent Care's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

___Patient refused to sign

___ Patient had a medical emergency

___Other reason (describe below)

____

____

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Employee Name (Print) Signature