



Patient Registration Form

Please complete both sides of this form. If you are an existing patient of EGUC please complete the shaded areas only

Reason for visit

Patient Information

Last Name: _____ First Name: _____
Social Security Number: _____ Date Of Birth: _____ Sex: Female/Male
Address: _____ City: _____ State: _____
Zip code: _____ Phone Number: _____ Cell Phone: _____
Marital Status: Singe/Married/Widowed/Divorced
Employer Name & Address: Address: _____ City: _____ State: _____
Zip code: _____ Phone Number: _____

Guarantor for Minor: Authorization to Treat Minor

Last Name: _____ First Name: _____
Social Security Number: _____ Date Of Birth: _____ Sex: Female/Male
Address: _____ City: _____ State: _____
Zip code: _____ Phone Number: _____ Cell Phone: _____
Relationship to patient: Spouse/Father/Mother/Guardian
Parent or Legal Guardia Signature: _____ Date: _____

Insurance Information (Copy of insurance card is required)

Name of Primary Insurance: _____
Name of Primary Insured: _____ Date of Birth: _____
Address: _____ City: _____ State: _____
Zip code: _____ Phone Number: _____ Cell Phone: _____
Relationship to patient: Spouse/Father/Mother/Guardian
Primary Care Physician: _____
Name of Secondary Insurance: _____
Name of Primary Insured: _____ Date of Birth: _____
Address: _____ City: _____ State: _____
Zip code: _____ Phone Number: _____ Cell Phone: _____
Relationship to patient: Spouse/Father/Mother/Guardian

Emergency Contact Information

Last Name: _____ First Name: _____
 Address: _____ City: _____ State: _____
 Zip code: _____ Phone Number: _____ Cell Phone: _____
 Relationship to Patient: Spouse/Father/Mother/Guardian

Consent for Treatment:

I consent to the performance of all routine medical care and treatment (e.g. tests, therapy, medical treatment or procedures, etc.) which may be performed as deemed necessary by and under the general and special instructions of the physician and/or authorized health care providers of Elk Grove Urgent Care.

Release of Information:

I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, or as otherwise permitted or required by law, Elk Grove Urgent Care may disclose any portion of my/ the patient's medical records including but not limited to, information about my/ the patient's diagnosis and /or treatment relating to medical, mental health, developmental disability, and/or substance abuse treatment to any person, regulatory or government agency, or corporation including, but not limited to, insurance companies, or health care service plans which are, or may be liable for, all or any portion of Elk Grove Urgent Care's charges. To ensure coordination of my/ the patient's ongoing care and treatment, I also release of any medical information to my/ the patient's primary care physician or health care provider and any consulting physicians or health care providers participating in my/ the patient's care.

Privacy notice: HIPPA

By signing this section, you acknowledge receipt of Notice of Privacy Practices of Elk Grove Urgent Care provides information about how we may use or disclose your protected health information. We encourage you to read it in full.

Printed Name of Patient: _____

Signature: _____ Date: _____

Authorization:

The undersigned certifies that he/she has read the information noted above and has been given the opportunity to have any questions answered fully and to his/her satisfaction, and has the option to receive a copy of this agreement upon request. The undersigned further certifies that he/she is 1) the patient or 2) the patient's legal representative or 3) is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature of patient or parent: _____ Date: _____

Please tell us, how did you hear about Elk Grove Urgent Care?(check all that apply)

- Internet TV Radio Newspaper Other _____
 Existing Patient Friend Magazine Mailer
 Physician Referral Employer Signage Yellow Pages

