Urgent Care Center

TLC Urgent Care Center
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Patient Registration Form

Welcome to our office. In order to serve you properly, we need the following information. All information is strictly confidential.

Date: ______________________

Patient's Name: ______________________ (Last) ______________________ (First) ______________________ (Middle) ______________________ (Nickname)

Date of birth: ______________________ [ ] Age   Sex: ☐M ☐F   Social Security #: [ ] [ ] [ ]

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Spouse ☐Guardian

Local Mailing Address: ______________________
____
City: ______________________ State: ________ Zip: ________

Alternate Mailing Address: ______________________
____
City: ______________________ State: ________ Zip: ________

Home Phone: ______________________   Work Phone: ______________________ Ext.: ________

Cell: ______________________   E-mail: ______________________

Name of Spouse/Parent: ______________________ Phone: ______________________

Address: ______________________

Nearest Relative Name/Address: ______________________

Relationship: ______________________ Phone: ______________________

Name of Person to notify if Emergency: ______________________

Address: ______________________ Phone: ______________________

Patient Employment: ☐Employed ☐Retired ☐Self-Employed ☐Disabled ☐Unemployed ☐Other

Employer: ______________________ Occupation: ______________________

Address: ______________________ Phone: ______________________
____

Primary Insurance Name: ______________________

ID#: ______________________ Group#: ______________________ Phone: ______________________

Secondary Insurance Name: ______________________

ID#: ______________________ Group#: ______________________ Phone: ______________________

Worker's Compensation Company Name: ______________________ D.O.A.: ______________________

Insurance: ______________________ Group#: ______________________ Phone: ______________________

Auto Insurance Name: ______________________ D.O.A.: ______________________

Policy#: ______________________ Phone: ______________________

Referral Information: ☐Walk-In ☐Internet ☐Phone Book ☐Ad ☐Radio

Referred by: ______________________

Please present your insurance card(s) so that we may make copies for your records.