PMC | URGENT CARE
& OCCUPATIONAL MEDICINE
Patient First. Quality Care.

REGISTRATION FORM

(Please Print)

Who is your Primary Care Physician?:	Today's Date:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	Birth Date: / /	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Social Security No.: - -	Age:	Sex: ❑ M ❑ F

Street address:	Home Phone No.: ( )	Cell Phone No.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone No.: ( )

Do you have email? ❑ No ❑ Yes If so, what is your email?

What is the reason for your visit:

Pharmacy:

RESPONSIBLE PARTY/INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone No.: ( )

Is this person a patient here? ❑ Yes ❑ No Social Security No. / /

Occupation:	Employer:	Employer address:	Employer Phone No.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No, this will be Self-Pay

Please indicate **Primary Insurance** ❑ Anthem/Blue Cross ❑ Aetna ❑ Assurant ❑ Cigna ❑ Humana

❑ Indiana Medicaid ❑ Medicare ❑ Pekin Life ❑ Tricare ❑ Other (Please Write Name)

Do you have an assigned physician ❑ No ❑ Yes – If so, who?

Subscriber's name:	Subscriber's S.S. N.:	Birth date: / /	Group No.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of **Secondary Insurance** (if applicable):

Subscriber's name:	Subscriber's S.S. N.:	Birth date: / /	Group No.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone No.: ( )	Work phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. **I understand that I am financially responsible for any balance.** I also authorize PMC Urgent Care or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*