# CALDER URGENT CARE

## PATIENT REGISTRATION

**PLEASE FILL OUT THE ENTIRE FORM** **DATE______________**

Reason for visit today: ___________________________________________________________________________

Is this visit related to a motor vehicle accident or Work Related Injury? ____Yes ____No DOI_______

**PATIENT INFORMATION**

**First Name:______________________________ Last Name ________________________________M_______**

**Date of Birth:____/____/_____ Social Security Number _______/_______/______ Male ____Female______**

**Marital Status: ________ Married _____Single ______Divorced ____ Widowed ___ Legally Separated ____ Other**

**Address: ____________________________________City ________________State _________Zip______________**

**Telephone: Home:_______________________ Mobil _________________________Work________________________**

**May we Contact you at work? ____Yes _____No Email Address:___________________________________________**

**Employer:________________________________________________________Phone__________________________**

**Emergency Contact Name _____________________________Relationship ___________ Phone___________________**

**PHARMACY**

**Name:______________________________________________________________Phone______________________**

**PRIMARY INSURANCE INFORMATION (Provide your insurance card to the front desk)**

**Name of Insured___________________________________________Relationship to Patient___________________**

**Insurance Carrier__________________________________________ Phone Number _________________________**

**ID#__________________________________________ Insured Date of Birth ____/____/____ Group_______________**

**Primary Care Physician:_____________________________________ Phone Number: _______________________**

**Do you have Secondary Insurance Coverage? ____________________________________________________________**

**How do you hear about us?____________________________________________________________________**

**I have received a copy of the privacy policies.**

**Name__________________________________________________________________Date___________________**

**I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge**

**Patient (or Responsible Party) Signature____________________________________________Date______________**