REGISTRATION

VIRGINIA GATEWAY URGENT CARE CENTER

Date:_____

Patient Primary Care Physician:_____

How did you hear about us?_____

_____

Patient Information:

PATIENT LAST NAME:_____ FIRST:_____ MIDDLE:_____

If Minor, Person Responsible For Patient and Charges_____

Responsible Party DOB:_____ Responsible Party Social Security No._____

Patient Birthdate:_____ Sex:_____ Patient Social Security No.:_____

Race:_____ Ethnicity:_____ Language: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employer:_____ Marital Status:_____ Email:_____

Emergency Contact Name:_____ Phone:_____ Relationship:_____

Preferred Pharmacy:_____ Pharmacy Street:_____

Pharmacy City and State:_____ Pharmacy Phone:_____

Primary Insurance Company Name:

Subscriber's Name:_____ Subscriber Birthdate:_____

Relationship to Patient:_____ Subscriber's Employer_____

Social Security No. of Subscriber:_____

Secondary Insurance Company Name:

Subscriber's Name:_____ Subscriber Birthdate:_____

Relationship to Patient:_____ Subscriber's Employer_____

Social Security No. of Subscriber:_____

The above information is true to the best of my knowledge. I consent to treatment and tests by Virginia Gateway Urgent Care Center providers and staff. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Virginia Gateway Urgent Care Center or Insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____Date:_____

Printed Patient/Guardian Name:_____