

Urgent Care Center, LLC.

1701 Main Avenue, S.W., Suite A

Cullman, Alabama 35055

PATIENT REGISTRATION

Date: _____

Patient Name: Last _____ First _____ Middle _____

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

Telephone: () _____ Cell Phone: () _____ Sex: _____ M _____ F Race: _____

Date of Birth: _____ Social Security #: _____ Ethnicity: _____

Employer: _____ Employer Phone: _____

Primary Physician: _____ Marital Status: _____

Spouse Name: _____ Date of Birth: _____

Employer: _____ Employer Phone: _____

Another person to contact in case of an emergency (not in your household):

Name: _____ Phone: _____ Relationship: _____

IF MINOR

Father's Name: _____ Date of Birth: _____

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

Employer: _____ Employer Phone: _____

Mother's Name: _____ Date of Birth: _____

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

Employer: _____ Employer Phone: _____

PRIVACY COMPLIANCE

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis, which might include medical history, treatment, laboratory reports, x-rays, and treatment and/or reference to any mental or nervous disorders, drug and/or alcohol abuse, or sexually transmitted disease.

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

Please print the telephone number(s), if any, where you want to receive calls about your appointments, lab, x-ray results, and/or other health information, if other than your home phone number or cellular number:

Can confidential messages be left on your home answering machine or voice mail (for example, appointment reminders)? Yes _____ No _____

I hereby authorize Urgent Care Center, LLC to furnish to my primary physician and insurance company(s) all information which said physician or insurance company(s) may request. I hereby assign to Urgent Care Center, LLC all money to which I am entitled for medical/surgical expense relative to the service rendered but not to exceed my indebtedness to the professional company. I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree to pay 27.00% of principal balance for collection costs should account be placed with a collection agency or attorney plus court costs expended. I hereby give permission to Urgent Care Center, LLC and their billing office to contact me via the numbers I have provided on issues associated with my account to include cellular numbers connected with me or my account. I hereby consent to treatment.

PATIENT'S SIGNATURE : _____ Date: _____

PARENT AND/OR GUARDIAN'S SIGNATURE: _____ Date: _____