PATIENT REGISTRATION FORM

Office Use Only:_____ (CSR initial)
**My initial signifies that this form has been completed and has been uploaded into the EMR*

PATIENT INFORMATION

SSN:_____ Home Phone:_____

First Name:_____ Cell Phone:_____

Last Name:_____ Email Address:_____

Provide your email and receive specials, health topics, & more!

Middle Name:_____ Date of Birth_____/_____/_____

Mailing Address:_____

Sex: ❑ M OR ❑ F Race:_____ Preferred Language:_____ Hispanic/Latino: ❑ YES ❑ NO

How did you hear about us? ❑ Drive By ❑ Insurance ❑ Doctor ❑ Employer ❑ Friend/Family ❑ Hotel ❑ Internet ❑ First Aid Station/Event (Please specify):_____

Preferred Pharmacy Location:_____ **Please indicate specific location and city of preferred pharmacy.*

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician:_____ **Phone Number:**_____

❑ I do not have a Primary Care Physician ❑ I don't know who my primary care physician is

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone Number:_____

PERSONAL INSURANCE COVERAGE

Primary Insurance:_____ Secondary Insurance:_____

Name of Policy Holder:_____ Name of Policy Holder:_____

Member ID Number:_____ Member ID Number:_____

Group Number:_____ Group Number:_____

Policy Holders SSN:_____ DOB:___/___/___ Policy Holders SSN:_____ DOB:___/___/___

Relationship to Patient:_____ Relationship to Patient:_____

GUARANTOR'S INFORMATION **Please include your information if you are checking in a patient younger than 18 years old.*

First Name:_____ Last Name:_____

Date of Birth:_____ SSN:_____ Phone Number:_____

Address:_____

Street Address *City/State/Zip Code*

I certify that the information provided is correct to the best of my knowledge. I will not hold Urgent Care Hawaii, LLC, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form. I understand that URGENT CARE HAWAII may contact me with any given contact information provided on this form, this includes my Guarantor's Information and/or Emergency Contact. By signing below, you expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, URGENT CARE HAWAII, LLC, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Print Name of Patient or Guardian:_____

Signature of Patient or Guardian:_____ **Date:**_____