minden emurgent care

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status: OTHER

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ☐ M ☐ F

Address:	Email Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Referred by: ☐ Friend/Relative ☐ Ad (Location_____) ☐ Internet/Google ☐ Employer ☐ Other:_____
☐ Physician ☐ Drive By

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different than above):	Home phone no.:
Is this person a patient here?	☐ Yes ☐ No	Is this patient covered by insurance?	☐ Yes ☐ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: | Other: (Worker's Comp, Motor Vehicle, etc.)

Subscriber's name:	Subscriber's social security number (required for billing):	Birth date:	Group number:	Policy number:

Patient's relationship to subscriber (circle one): ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name of secondary insurance (if applicable):	Subscriber's name:	Group number:	Policy number:

Patient's relationship to subscriber (circle one): ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient: Other	Primary phone number:	Work phone number:

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 Emurgent Care Minden or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date