PATIENT REGISTRATION

(Title) ______ Patient Name (Last) __________________________ (First) _______________________ (MI) _____

Reason for Visit ____

Address____ Apt# _________

City __________________________________ State ______ Zip Code ___________

Home Phone ____________________ Cell Phone ________________________

E-Mail Address ____

Date of Birth: MM ______/DD ______/YYYY _______ Age: ________ SSN: _______-_____-_________

Sex: Female Male Transgender

Ethnicity: Hispanic or Latino Not Hispanic or Latino Other___________________

Race: White African American Asian Pacific Islander American Indian Declined

Language: English Spanish Creole Other ___________________

Marital Status: Married Single Divorced Widowed Partner

Employment Status: *(select all that apply)* Full-Time Part-Time Not Employed Self-Employed Retired Active Military Full-Time Student Part-Time Student

SOCIAL SECURITY NUMBER

I voluntarily give UHealth Jackson Urgent Care my social security number if needed to identify me and file charges with my insurance company. UHealth Jackson Urgent Care will follow any federal and state laws about the use and protection of my Social Security Number.

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** ___________________

FINANCIAL DISCLOSURE

For patients with health insurance, please note that you will be asked to pay your copayment upon completion of your visit today. For patients without health insurance, an initial visit fee of $150.00 will be requested upon your registration, prior to seeing an Urgent Care Medical Provider. Upon completion of your visit, you will be asked to pay for any additional medical services rendered during your visit.

HOW DID YOU HEAR ABOUT US?

Family/Friend
Doctor
Event
Google

Website
Facebook
Twitter
Internet Ad

Newspaper
Billboard
TV News
Other _____________