Tchefuncta
urgent care

Patient Registration Form

Patient Name: Last _____ First _____ MI _____ DOB: _____

Social Security #: ___-___-___ Gender: M / F Primary Care Physician: _____

Race _____ Ethnicity _____

Preferred Language _____ E-Mail: _____

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

Home: (___) _____ Cell: (___) _____ Other: (___) _____ Work: (___) _____

Best Form of Contact: H / W / C / Other Best Time to Call _____

Employer: _____ Phone: (___) _____ Position: _____

Emergency Contact: Name _____ Phone: (___) _____ Relationship: _____

Primary Insured / Responsible Party

Last Name: _____ First Name: _____ MI: _____ DOB: _____

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

Relationship to patient: _____ Gender (circle one): M / F Social Security #: ___-___-___

Employer: _____ Home: (___) _____ Cell: (___) _____ Other: (___) _____

Secondary Insured / Responsible Party

Last Name: _____ First Name: _____ MI: _____ DOB: _____

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

Relationship to patient: _____ Gender (circle one): M / F Social Security #: ___-___-___

Employer: _____ Home: (___) _____ Cell: (___) _____ Other: (___) _____

Consent for services and / or disclosure of Protected Health Information

I hereby consent to medical evaluations, testing and / or treatment provided to me by the staff of Tchefuncta Urgent Care. I also understand that Tchefuncta Urgent Care may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor and agree to pay any remaining balance once my Insurance Plan has processed my claim.

_____ _____

Signature of patient or parent/guardian if minor Date