PATIENT REGISTRATION

Reason(s) for your visit today_____

PHARMACY location_____Phone_____

(CIRCLE) Y N For best patient care, I authorize 1st Class Urgent Care to download my medication information from my pharmacy.

LAST NAME_____FIRST NAME_____M.I._____

ADDRESS_____APT #_____

CITY_____STATE_____ZIP_____P.O. Box_____

SEX____MARITAL STATUS (CIRCLE) S M D W DATE OF BIRTH_____AGE____SS#_____

Person who carries your insurance _____DOB_____PHONE_____

EMAIL ADDRESS_____EMPLOYER_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

RESPONSIBLE PARTY: LAST NAME_____FIRST NAME_____

ADDRESS_____APT#_____

CITY_____STATE_____ZIP_____

EMERGENCY CONTACT_____RELATIONSHIP_____PHONE_____

PRIMARY CARE PHYSICIAN_____PHONE_____

RACE (CIRCLE) American Indian or Alaska Native Black or African American

Asian White

Native Hawiian or Other Pacific Hispanic

Other Race_____

ETHNICITY (CIRCLE) HISPANIC OR LATINO NOT HISPANIC OR LATINO jjREFUSED TO REPORT

HOW DID YOU LEARN ABOUT 1ST CLASS URGENT CARE? _____

PAYMENT TERMS: Copays and coinsurance are due at time of service. We will run an estimate at the time of service to determine what insurance will cover and what your responsibility is. You are responsible for any unpaid balance or full payment is insurance is denied. There is a $50 fee for returned checks. By signing below, you acknowledge full responsibility for all services provided to you and agree to pay all expenses including collection and attorney fees if necessary to collect your balance. Your visit constitutes a credit transaction and as such, we or our agents have permission to report unpaid balances to the credit bureaus and may seek address and employment information as necessary to effect collection of an unpaid balance.

_____ _____

PATIENT, PARENT, OR GUARDIAN SIGNATURE **DATE**