URBANCARE
INTERNAL MEDICINE & PEDIATRICS

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name_____ Date of Birth_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone (_____)_____ Cell Phone (_____)_____

Business Phone (_____)_____ SS# _____

Sex of Patient: ( ) Male ( ) Female

Are you: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Other_____

Name of Spouse_____

Preferred Contact Method ( ) Home Phone ( ) Cell Phone ( ) Email
( ) Portal (UrbanCare's preferred method)

Race/Ethnicity (check all that apply)

( ) Asian ( ) Black/African American ( ) Hispanic/Latino ( ) Alaska Native
( ) Native American ( ) Pacific Islander ( ) Bi-Racial ( ) White/Caucasian
( ) Unknown ( ) Other_____ ( ) Disclosure Declined by Patient

Do you have an Advanced Directive (DNR, Living Will)? ( ) Yes (please provide copy) ( ) No

PATIENT EMPLOYMENT INFORMATION (Parent or Guardian employment if patient is a minor)

Employer_____

Employer Address_____

Work Phone (_____) _____ Occupation_____

If the patient is a minor, the person responsible for the child completes the following (Responsible Party)

Name of Responsible Party_____

Relation to the child ( ) Parent(s) ( ) Foster Parent(s) ( ) Legal Guardian ( ) Other _____

Responsible Party's Address_____

Responsible Party's Home Phone_____

Responsible Party's Cell Phone_____

Responsible Party's Work Phone_____

(Continues on next page)

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INSURANCE INFORMATION

Primary Insurance

Insurance Company Name_____ Copay Amount_____

Name of Policy Holder_____

Policy Holder Birthdate _____ Policy Holder Relationship to Patient_____

Policy Holder's Employer_____

Group Number_____ Policy ID Number_____

Secondary Insurance

Insurance Company Name_____ Copay Amount_____

Name of Policy Holder_____

Policy Holder Birthdate _____ Policy Holder Relationship to Patient_____

Policy Holder's Employer_____

Group Number_____ Policy ID Number_____

EMERGENCY CONTACT

Name_____Relationship_____

Address_____

Home Phone (_____)_____ Cell Phone (_____)_____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS/CONSENT FOR TREATMENT

I authorize the release of any medical information necessary to process my insurance claim(s) or as needed by my insurance carrier. I authorize and request payment of medical benefits directly to UrbanCare, LLC. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

I also consent for treatment for myself (any minor children in my care) by UrbanCare, LLC. I have reviewed the above information and to the best of my knowledge it is correct as written. I hereby agree to the Release of Authorization/Assignment of Benefits.

_____ _____

Signature of Patient (Representative) Date