statcare
Urgent & Walk-In Medical Care

PATIENT REGISTRATION INFORMATION

Patient Name: Last _____ First_____MI ____

Date of Birth: _____/ ____ / ____ Social Security #:_____-_____-_____ Email: _____ @ _____

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

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ Other: (_____) _____- _____

Gender: [ ] Male [ ] Female [ ] Other Please Specify: _____

Language: [ ] English [ ] Spanish [ ] Sign Language [ ] Other: _____

Race: [ ] Black [ ] Hispanic [ ] White [ ] Other: _____

Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino

Please notify the staff of a disability that may require special needs or of a barrier to communication or educational instruction that would prevent the understanding of information about the patient's health status, treatment, or the informed decision making process, such as; foreign language, hearing or speech impairment, difficulty with reading or writing or inability to comprehend verbal instruction. Assistive services within our capability will be provided to you free of charge.

Emergency Contact: _____ Phone: (_____) _____- _____ Relationship: _____

Guarantor / Responsible Party for minor

[ ] Check box if address and phone number is the same as the patient's information.

Last Name:_____ First Name:_____ MI: ____
Relationship to patient: _____
Date of Birth: _____/____/ ____ Guarantor Social Security #:_____-____-_____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____- _____ Cell Phone: (_____) _____- _____ Other: (_____) _____- _____
Guarantor Employer: _____ Phone: (_____) _____- _____

Primary Insurance Coverage

Insurance Company: _____ Name of Insured: _____
Relationship to Patient: _____ Insured D.O.B.:_____/ ____/ ____
Insured Social Security #:_____-____-_____

Secondary Insurance Coverage

Insurance Company: _____ Name of Insured: _____
Relationship to Patient: _____ Insured D.O.B.:_____/ ____/ ____
Insured Social Security #:_____-____-_____

I verify that the above information provided is true and correct to the best of my knowledge. I understand that the company will require me to update this information at least annually and as necessary when changes occur in my status.

X _____ Date:_____/ ____/ ____

Signature of Patient /Guardian/Accompanying Adult