URGENTWAY PATIENT REGISTRATION

Patient Information

Patient Full Name:

○ New Patient ○ Existing Patient

Reason for Visit:

Date of Birth: Gender: ○ Male ○ Female

Social Security #: Ethnicity/Race:

Local Address: Apt #:

City: State: Zip:

Primary Phone #: ○ Home ○ Cell ○ Work

Secondary Phone # : ○ Home ○ Cell ○ Work

Email Address: By providing your email address, you consent to our Privacy Policy

How did you hear about us?: ○ Existing Patient ○ Word of Mouth ○ Facility Signage
○ Internet/Online Search ○ Print Advertising ○ Radio ○ Phone Book/Yellow Pages
School/Daycare: _____ Employer: _____
Community Event: _____ Hotel: _____
Physician Referral: _____ Pharmacy: _____
Apartment Complex: _____ Insurance: _____

Primary Care Physician:

Employer:

Permanent Address (other than local):

City: State: Zip:

Marital Status: ○ Child ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Spouse's Full Name:

Guardian of Minors or Incapacitated Adults Only

Guardian's Full Name:_____

Guardian's Date of Birth:_____Contact #:_____

Guardian's Relationship to Patient:_____

Guarantor/Insurance Subscriber Information

Complete Only if Patient is NOT Guarantor

Guarantor Full Name:

Guarantor Date of Birth:

Guarantor Social Security #:

Guarantor Relationship to Patient:

Guarantor Permanent Address: Apt #:

City: State: Zip:

Guarantor Primary Phone #: ○ Home ○ Cell ○ Work

Guarantor Secondary Phone #: ○ Home ○ Cell ○ Work

Guarantor Employer:

Complete Insurance Details Only if Card is NOT Present in Clinic

Insurance Company:

Type: ○ HMO / PPO ○ Medicare ○ Medicaid/AHCCCS ○ Tricare ○ Other

ID / Policy #: Group #:

Copay Amount: Effective Date:

Secondary Insurance? ○ Yes ○ No Name:

Signature

Patient/Guardian Name:

Signature: Date:

Thank you for choosing Urgentway. Your satisfaction isimportant to us! Please leave your email address in the space provided and we will send you a survey about your visit today.