Registration-EB

(PLEASE PRINT)

☐ Workers Comp

☐ Motor Vehicle Accident

DATE:

PATIENT INFORMATION

Name _____ S.S.# _____
(LAST) (FIRST) (Middle Initial)

Address _____ Apt.# _____

City _____ State _____ Zip Code _____

Birth Date _____ Age _____ Sex ☐ M ☐ F
(Month) (Day) (Year)

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Occupation _____ Employer _____ Employer Phone # _____

PHONE NUMBERS

Home _____ Cell _____ Work _____

Emergency Contact: _____ _____ _____
(NAME) (PHONE) (RELATIONSHIP)

PRIMARY INSURANCE

Insurance Company _____

Subscriber ID # _____ Group ID # _____

Policyholder _____ Birth Date _____
(Last Name) (First Name) (Middle Initial) (Month) (Day) (Year)

Relation to Patient: ☐SELF ☐HUSBAND ☐WIFE ☐FATHER ☐MOTHER ☐OTHER S.S.# _____

Address(If Different Than Patient's) _____ Apt.#_____

City _____ State _____ Zip _____ Phone #_____

SECONDARY INSURANCE

Initial____

WE DO NOT PARTICIPATE WITH Medicaid

Insurance Company _____

Subscriber ID # _____ Group ID # _____

Policyholder _____ Birth Date _____
(Last Name) (First Name) (Middle Initial) (Month) (Day) (Year)

Relation to Patient: ☐SELF ☐HUSBAND ☐WIFE ☐FATHER ☐MOTHER ☐OTHER S.S.# _____

Address(If Different Than Patient's) _____ Apt.#_____

City _____ State _____ Zip _____ Phone #_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly
(Name of Insurance Company(ies))
to Brunswick Urgent Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Brunswick Urgent Care may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the above benefits payable for related services.

X _____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please PRINT name of patient, parent, guardian or personal Representative Relationship to Patient