



Rapid Care Medical Clinic
REGISTRATION FORM
 (Please Print)

INSURANCE

Today's date:				PCP: Rapid Care Medical Clinic			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss. <input type="checkbox"/> Ms.	Marital Status Single / Mar / Div / Sep / Wid	
Are yo allergic to any medicine? <input type="checkbox"/> yes <input type="checkbox"/> No	If so, what medicine?		Are you over 18 yr old?	Birh Date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:			Social Security no.:		Home phone.: ()		
Apt #:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone: ()		
Chose clinic because /Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other	

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth Date: / /		Address (if diferent)		Home phone.: ()	
It this person a patient here? <input type="checkbox"/> yes <input type="checkbox"/> No							
Occupation:		Employer:		Employer Address:		Employer phone number.: ()	
Is this patient covered by insurance? <input type="checkbox"/> yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Culinary	<input type="checkbox"/> BCBS		<input type="checkbox"/> Sierra	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Aetna	<input type="checkbox"/> Great west	<input type="checkbox"/> Beech Street	<input type="checkbox"/> United Healthcare		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S no.:	Birth date: / /	Group no.:		Policy no.:	Co- payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()
			Work phone no.: ()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understnd that I am finacually responsible for any balance. I also authorize Rapid Care Medical Clinic or insurance company release any information required to process my claims.

 Patient/Guardian signature

 Date