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:	☐ Mr. ☐ Mrs.	☐ Miss. ☐ Ms.	Marital Status Single / Mar / Div / Sep / Wid

Are yo allergic to any medicine? ☐ yes ☐No	If so, what medicine?	Are you over 18 yr old?	Birh Date: / /	Age:	Sex: ☐ M ☐ F

Street Address:	Social Security no.:	Home phone.: ( )

Apt #:	City:	State:	ZIP Code:

Occupation:	Emloyer:	Employer phone: ( )

Chose clinic because /Referred to clinic by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ 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? ☐ yes ☐No

Occupation:	Employer:	Employer Address:	Employer phone number.: ( )

Is this patient covered by insurance? ☐ yes ☐No

Please indicate primary insurance	☐ Culinary	☐ BCBS	☐ Sierra	☐ Medicare	☐ Medicaid

☐ Aetna	☐ Great west	☐ Beech Street	☐ United Healthcare	☐ Other

Suscriber's name:	Suscriber's S.S no.:	Birth date: / /	Group no.:	Policy no.:	Co- payment: $

Patient's relationship to suscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Suscriber's name:	Group no.:	Policy no.:

Patient's relationship to suscriber:	☐ Self	☐ Spouse	☐ Child	☐ 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 responsable 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