Patient Sticker

UNC Urgent Care

Patient Registration Form

REASON FOR VISIT: ____

PATIENT INFORMATION (UNC Rex Healthcare will compare your legal name to your legal identification card.)

Patient's Legal Name (Last, First, Middle) ____

Preferred Name______________________________

Social Security Number ______-______-________ Sex______ Date of Birth ____/____/____

Permanent Address ____________________________________ City ______________ State_____

Zip____________ County______________________

Home Phone (______)_____________ Work (______)______________ Mobile (______)________________

Email ______________________________________

GENERAL INFORMATION

Need Interpreter? (*Please Circle One*) YES / NO Preferred Language _________________________

Marital Status: (*Please Circle One*) Single / Married / Widowed / Separated / Divorced / Domestic Partner

Ethnicity: (*Please Circle One*) Hispanic / Non-Hispanic / Other / Patient Refused

Race: (*Please Circle One*) African American / Asian / Caucasian / American Indian / Other Race / Patient Refused

Veteran Status: YES / NO / Decline / Currently Serving Homeless: YES / NO

PRIMARY CARE PHYSICIAN

MD First and Last Name _____________________________ and/or Practice Name ________________________

Phone Number (______)__________________

EMPLOYMENT (*Please Circle One*) Full time / Part Time / Retired / Not Employed / Self Employed / Disabled / Student

Employer ______________________________________ (If Retired) Date of Retirement _____/_______/_____

Is your reason for visit work related? YES / NO

(If work related, please fill out Workman's Compensation Treatment Authorization Form)

EMERGENCY CONTACT INFORMATION

Name (Last, First) ________________________________ Relationship ______________________________

Primary Phone (______)__________________ (*please circle one*) Home / Work / Mobile

Patient Sticker

UNC Urgent Care

Patient Registration Form

ACCIDENT RELATED VIST INFORMATION

Accident or Injury? YES / NO Motor Vehicle Accident related? YES / NO

If you answered YES to any of the questions above please provide the following information:

Date of accident/injury ____/_____/_____ Time of accident/injury____________ pm / am

*Brief description of what happened:

____

____

*If this happened at your workplace while you were on the clock and you are filing Workman's Compensation please fill out the description section above as well as the Workman's Compensation Treatment Authorization Form. Thank you.

GUARANTOR (This section should be the information of the person bringing the minor into the urgent care today.)

Name (Last, First) __________________________________ Date of Birth _______/________/________

Address ____City _________Zip_________ State________

Phone (_____)_______________________ Social Security Number _______-________-_________

Relationship to Patient ________________

PRIMARY INSURACE COVERAGE

Primary Insurance Name ____________________________ SS# of Policy Holder _____-_______-______

Policy Holder Name________________________________ DOB______/_______/_______

Relationship to patient______________________________ Subscriber ID _________________________

Address____City/State/Zip__________________________

Employer/Group Name______________________________ Group Number________________________

Covered Through: Other / Current Employment / Retirement / Cobra

SECONDARY INSURACE COVERAGE

Primary Insurance Name ____________________________ SS# of Policy Holder _____-_______-______

Policy Holder Name________________________________ DOB______/_______/_______

Relationship to patient______________________________ Subscriber ID__________________________

Address____City/State/Zip__________________________

Employer/Group Name______________________________ Group Number________________________

Covered Through: Other / Current Employment / Retirement / Cobra