Advanced Medical Center

PLEASE PRINT

REGISTRATION FORM

Today's Date: Physician (PCP):

PATIENT INFORMATION

Legal Name Last:	First:		Middle:
Social Security No.:	Birth Date:	Sex ◻F ◻M	Nickname/Goes By:
Billing Address:		City:	State, Zip:
Secondary Address:		City:	State, Zip:

GOVERNMENT MANDATED INFORMATION

Language: ◻English ◻Spanish ◻Other________________________ | Ethnicity: ◻Hispanic/Latino ◻Not Hispanic/Latino

Race: ◻American Indian/Alaska Native ◻Asian ◻Black/African American ◻Hispanic/Latino ◻Native Hawaiian/Other Pacific Islander ◻White

Contact Preference: ☐Cell Phone ☐Home Phone	Email:	
Marital Status: ◻Single ◻Married ◻Divorced ◻Separated ◻Widow	Student Status: ☐Full Time ☐Part Time ☐Not A Student	
Home Phone No.: ( )	Daytime Phone No.: ( )	Cell Phone No.: ( )
Employment: ☐FT ☐PT ☐Retired ☐Self Employed ☐Not Employed	Employer:	

GUARANTOR INFORMATION (Must complete Parent/Legal Guardian Form if Patient Under Age 18)

Person Responsible for Bill: ☐Self ☐Other Specify Other:	Address (*if differs from above*):	Home Phone No: ( )

INSURANCE INFORMAITON

Is this patient covered by insurance? ☐Yes ☐No	Is the policyholder a patient here? ☐Yes ☐No
Insurance Company:	Subscriber Name:
Member ID:	Relation to Subscriber:
Group Name	Insurance Company Phone No.:
Employer:	
Secondary Insurance Company:	Subscriber Name:
Member ID:	Subscriber Date of Birth:
Group Name	Relation to Subscriber:
Employer:	Insurance Company Phone No.:

PHARMACY INFORMATION (For EHR Entry Only)

Pharmacy Name:	Pharmacy Phone No: ( )

Permission to access Sure Scripts (electronic pharmacy) for the viewing of all Electronically recorded medications: ☐Yes ☐No Please Initial_____________

EMERCENCY CONTACT (For EHR Entry Only)

Name of local friend or relative (not living at same address):	Relationship to Patient: Phone Number:

ACKNOWLEDGEMENT OF TRUE AND ACCURATE INFORMATION

The information reported on this document is true to the best of my knowledge. I hereby authorize the physicians and staff of Advanced Urgent Care to release any information acquired in the course of my treatment to my insurance company or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include HIV virus, Acquired Immune Deficiency Syndrome (AIDS), and mental health. I authorize direct payment to be made to the physicians of Advanced Family Practice for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if Advanced Family Practice is unable to verify eligibility, that I am responsible for all charges incurred for services rendered.

Signature ______________________ Date ______________