ARLINGTON URGENT CARE REGISTRATION

Please complete all sections of this form.

First Name: _____ Last Name: _____ MI: _____
Birthdate: _____SSN:_____ Gender: Male Female
Address: _____ City: _____ ST: _____ Zip Code: _____
Home Phone: _____ ☐OK to leave message Cell Phone: _____ ☐OK to leave message
Email: _____ Marital Status: _____
Race: _____ Ethnicity: Hispanic Non-Hispanic Preferred Language: _____
Reason for today's visit: _____ Primary Care Physician: _____
Emergency Contact: _____ Phone: _____Relationship:_____
Medications _____ OR ☐See attached list

☐ Medication Allergies:_____

☐ Allergies: _____

Preferred Pharmacy Name: _____ Address: _____
How did you hear about us? _____

☐I do not have private health insurance.
Primary Insurance: _____ Co-Pay: _____
Insured Name: _____ Relationship: _____ Birthdate: _____
SSN: _____ Gender: Male Female Phone: _____
Address: _____ City: _____ ST: _____ Zip Code: _____
Secondary Insurance if applicable: _____ Co-Pay: _____
Insured Name: _____ Relationship: _____ Birthdate: _____
SSN: _____ Gender: Male Female Phone: _____
Address: _____ City: _____ ST: _____ Zip Code: _____

☐**THIS IS A WORK RELATED INJURY. (Please alert the receptionist. You must still provide health insurance for work related injuries)**

If patient is under 18 who may authorize treatment?
Name: _____ Relationship: _____
SSN of Guardian: _____ Birthdate: _____ Phone: _____

Acknowledgement of Arlington Urgent Care Notice of Privacy Practices

- I hereby acknowledge that I have reviewed, received, or have been given the opportunity to receive a copy of Arlington Urgent Care's Notice of Privacy Practices.
- I have read, understand, and agree to the attached Financial Policy. I am aware that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. If I do not have health insurance, I will be responsible for all charges from today's visit and agree to pay in a timely manner.
- I authorize my insurance benefits be paid directly to Arlington Urgent Care.
- I authorize Arlington Urgent Care, through its appropriate personnel, to perform upon me, or the above named patient, appropriate assessment and treatment procedures.
- I authorize Arlington Urgent Care to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.
- I agree to have my insurance, or self, charged for all services utilized by an outside facility including, but not limited to, laboratory analysis.

Patient/Guardian Signature: _____ Date: _____

Please alert a staff member IMMEDIATELY if you are experiencing any of the following: CHEST PAIN, SHORTNESS OF BREATH, FACIAL DROOPING, SLURRED SPEECH AND/OR A TEMPERATURE ABOVE 101 DEGREES FARENHEIGHT.