



Patient Registration Form

NAME (LAST, FIRST, MIDDLE INITIAL) HOME PHONE NO. CELL PHONE NO. DOB

ADDRESS CITY STATE ZIP CODE

SOCIAL SECURITY NO. SEX (M/F) MARITAL STATUS LAST TETANUS

EMAIL ADDRESS

EMPLOYER INFO

OCCUPATION EMPLOYER WORK PHONE NO.

EMPLOYER ADDRESS CITY STATE ZIP CODE

PRIMARY INSURANCE INFO Please provide copy of Insurance Card

INSURED'S NAME INSURED'S DATE OF BIRTH

INSURED'S PHONE NO. INSURED'S SOCIAL SECURITY NO.

INSURED'S ADDRESS (IF DIFFERENT THAN ABOVE) CITY STATE ZIP CODE

SECONDARY INSURANCE INFO Please provide copy of Insurance Card

INSURED'S NAME INSURED'S DATE OF BIRTH

INSURED'S PHONE NO. INSURED'S SOCIAL SECURITY NO.

MINOR / GUARANTOR'S INFO

NAME OF RESPONSIBLE PARTY RELATIONSHIP TO PATIENT RESPONSIBLE PARTY'S DOB

RESPONSIBLE PARTY'S SOCIAL SECURITY NO. DRIVER LIC NO. PHONE NO.

ADDRESS (IF DIFFERENT THAN ABOVE) CITY STATE ZIP CODE

I, the undersigned, being the patient or parent/legal guardian/person having legal custody/or person having legal authorization to consent, freely give my consent to Newport Urgent Care (NUC), and their agents, to examine and treat the patient registered/referenced above. I authorize NUC to release any medical records that may be requested by a 3rd party for the purpose of paying for services rendered, and further authorize the payment from any such medical benefits be made directly to NUC.

By using insurance for this and other visits, I understand it is my responsibility to know the terms and conditions of my coverage and to provide a copy of the most current insurance card. I know I have the right to decline treatment recommended by the provider. If I am provided service that is not covered by my insurance, or if my insurance coverage has lapsed, I will be responsible for the charge in full. I understand that if my insurance has not paid after 45 days from the billing date that I will be billed directly.

By signature below or acceptance of services, I am fully aware that I am financially responsible for all services provided for me by Newport Urgent Care. If I am using insurance, I understand NUC will bill my insurance and accept as payment in full the amount the insurance pays, with the exception of co-pays, deductibles, amounts designated as patient responsibility by the insurance, or non-covered services. I also understand that NUC reserves the right to bill at a later date for any missed charges for the date of service.

Signature of patient/parent or legal guardian

Date: