Your Doctor's Immediate Care
REGISTRATION FORM

Today's date:					
PATIENT INFORMATION					
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
SSN:	Birth date: / /	Age:	Sex: ❑ M ❑ F		
Mailing address:		Home phone #: ( )			Cell #: ( )
City:		State:			ZIP Code:
Email:	Employer:				Employer phone #: ( )
Employment Status: Full Time Part Time RETIRED		How did you hear about us?			
Primary Care Physician:					
Pharmacy: (Name, City, St)					
PLEASE CHECK HERE IF NO HEALTH INSURANCE: _____					

INSURANCE INFORMATION			
(Please give your co-pay, insurance card and driver's license to the receptionist.)			
Person responsible for bill:	Birth date: / /	SSN:	
Address (if different):	Home Phone #: ( )	Cell #: ( )	
Name of **PRIMARY** insurance:			
Policy Holder's Name:	**Policy Holder's SSN:**	**Birth date:** / /	Co-payment: $
Patient's relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of **SECONDARY** insurance (if applies):			
Policy Holder's name:	**Policy Holder's SSN:**	**Birth date:** / /	
Patient's relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements, promptly upon their presentation. I authorize payment directly to Your Doctor's Immediate Care, LLC from my insurance company. I hereby authorize the release of any medical information necessary in order to process a claim for payment in my behalf.

Patient/Guardian signature ***Date***