Patient Registration

Your insurance card and photo id are required at the time of your visit.

Classen Urgent Care Clinic

Classen Family Medicine

Last Name: _____ First Name: _____ MI: _____

DOB: _____ (mm/dd/yyyy) Sex: _____ SS#: _____ - _____ - _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Race: American Indian, Asian, Black, Hawaiian, Hispanic, White **Ethnicity:** Hispanic or Latino Y or N

Responsible Party (COLLEGE STUDENTS MUST PROVIDE AN ALTERNATE ADDRESS TO SEND BILLS)

Name: _____ Relation: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Social Security Number: _____-_____-_____ DOB: _____

Where do you want the bill to be sent: _____My Address _____Responsible Party Address

Emergency Contact Information

Contact First Name: _____ Contact Last Name: _____

Contact Phone: _____

Relationship to Patient: _____ Address: _____

City: _____ State: _____ Zip: _____

How did you find us? _____

Other Family Seen Here

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Primary Care/Other Physician

Physician Name: _____ Practice Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Employment Status *(Circle one)*

Employed Unemployed Full Time Student Part Time Student Retired

Business Name: _____ Business Phone: _____

Is this an on the job accident? Yes No

Date of Injury _____

Is this a motor vehicle accident? Yes No

I agree and consent to releasing information to me in the following manners: *(Please initial)*

Via Mail Ok to mail to home address _____
Via Home Telephone Ok to leave detailed message _____
Via Work Telephone Ok to leave detailed message _____

Via Email Ok to leave detailed message _____
Via Texts Ok to text for appointment reminders if applicable. _____

Any restrictions on the type of information? _____

Assignment of Insurance Benefits: I authorize payment directly to the CLASSEN URGENT CARE CLINIC LLC AND/OR CLASSEN FAMILY MEDICINE for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid by or billed to my insurance company or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co-pays, co-insurances, and deductibles today. If you are unable to verify my insurance at the time of service, I will pay for all services.

By signing below, I attest that the information provided above is true and accurate,

Signature of Insured/Guardian: _____ **Date:** _____