EFFINGHAM PromptCare Primary & Urgent Care

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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: **First Name:** **Middle Initial:** **Previous Names:**

Date of Birth: **Social Security Number:** **Sex:** ☐ Male ☐ Female ☐ Other

Race: *(Please Select One)*

☐ Caucasian ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native

Ethnicity: *(Please Select One)*

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Marital Status: *(Please Select One)*

☐ Single ☐ Married ☐ Divorced ☐ Other

Mailing Address:

City, State, Zip:

Home Phone: **Cell Phone:** **Email:**

Primary Care Provider: **Preferred Pharmacy Name & Location:**

Occupation: **Employer Name:**

Do you have insurance? ☐ Yes ☐ No **Primary Insurance:** **Secondary Insurance:**

Emergency Contact Name: **Emergency Contact Phone:** **Relationship to Patient:**

GUARDIAN INFORMATION (FOR PATIENTS UNDER THE AGE OF 18):

Last Name: **First Name:** **Relationship to Patient:**

Date of Birth: **Social Security Number:** **Phone Number:**

SIGNATURES

Signature of Responsible Party: _____ **Date:** _____

Printed Name of Responsible Party: _____