Walk-In Medical Urgent Care | URGENT CARE OF New York | Urgent Care of Westchester

ADULT PATIENT REGISTRATION FORM

Name First* _____ Middle : _____ Last Name*_____

Alias :_____ Age : _____ Date of Birth*: _____ Sex: _____

Race Ethnicity : _____ Language: _____ **Smoking Status: Y or N**

Address*_____

City* : _____ State* : _____ Zip Code*_____

Phone*: Cell _____ Home _____ Work _____

Email:_____

Preferred Pharmacy* : _____ City : _____

Reason for visit*:_____

Medications : _____

Allergies : _____

Medical History : _____

PERSONAL REPRESENTATIVE OF PATIENT

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to your Physician or picking your records up at this office.
Please be advised that it is your responsibility to inform us if any valid information has changed since your last visit, so we can bill your insurance correctly.
I hereby give permission to the person(s) listed below to authorize treatment, attend examination, and to receive information. This includes but is not limited to information about my general medical condition and diagnosis, treatment, access to medical records (PHI), prescription pick-up, ability to set appointments and payment options.

Emergency Contact

Name _____ Ph. # _____ Relationship : _____

Primary Care Physician

Name _____ Ph. # _____ Fax # _____

TREATMENT AND PAYMENT AUTHORIZATION

I authorize Walk-In Medical Urgent Care , PC (d/b/a Urgent Care of NY and Urgent Care of Westchester) for my treatment.
I understand that I must pay in full today for all the services rendered, if I do not have medical insurance or if you are not able to verify if my medical insurance is active. If my medical insurance is accepted by the medical facility, I am responsible to pay all the applicable insurance co-pays, co-insurance, and any deductibles at the time of service. I understand that I am financially responsible to pay all charges that are not paid by or billed to the insurance carrier or any other third party.

*Signature of the Patient : _____ *Date :_____

* Mandatory Fields