COMPASS URGENT CARE®

Patient Registration Form

Last name: _____ First Name: _____ MI: _____

SSN: _____-____-_____ Birth Date: _____/_____/_____ Gender {circle} MALE FEMALE

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

Cell Phone: (_____) _____-_____ ***Email:**_____@_____

Race: _____ Preferred Language: _____ Hispanic or Latino? Y/N

***Emergency Contact:** (First/Last Name) _____

Relationship: _____ Phone: (_____) _____-_____

***Pharmacy:** _____ ***Primary Physician:** _____

Primary Insurance: _____ Co-pay:_____

Insured Name: _____ Relationship: _____

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Phone: (_____) _____-_____

Secondary Insurance: _____ Co-pay: _____

Insured Name: _____ Relationship: _____

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Phone: (_____) _____-_____

*******Please list the person who will be responsible for any remaining bill*******

Guarantor Name: _____ Relationship: _____

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

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Phone: (_____) _____-_____

Authorization to Discuss Medical information

I,_____ give authorization for Compass Urgent Care to disclose my records to the following person(s) or personnel:

Name:_____ Relationship: _____

Name:_____Relationship: _____

***Reason for Visit:** _____