Brea Urgent CARE Inc. Occupational Medicine

www.breaurgentcare.com

Patient Registration Form

NAME (LAST, FIRST, MIDDLE INITIAL) | HOME PHONE NO. | CELL PHONE NO. | DOB

ADDRESS | CITY | STATE | ZIP CODE

SOCIAL SECURITY NO. | SEX (M/F) | MARITAL STATUS | LAST TETANUS

EMAIL ADDRESS

EMPLOYER INFO

OCCUPATION | EMPLOYER | WORK PHONE NO.

EMPLOYER ADDRESS | CITY | STATE | ZIP CODE

PRIMARY INSURANCE INFO Please provide copy of Insurance Card

INSURED'S NAME | INSURED'S DATE OF BIRTH

INSURED'S PHONE NO. | INSURED'S SOCIAL SECURITY NO.

INSURED'S ADDRESS (IF DIFFERENT THAN ABOVE) | CITY | STATE | ZIP CODE

SECONDARY INSURANCE INFO Please provide copy of Insurance Card

INSURED'S NAME | INSURED'S DATE OF BIRTH

INSURED'S PHONE NO. | INSURED'S SOCIAL SECURITY NO.

MINOR / GUARANTOR'S INFO

NAME OF RESPONSIBLE PARTY | RELATIONSHIP TO PATIENT | RESPONSIBLE PARTY'S DOB

RESPONSIBLE PARTY'S SOCIAL SECURITY NO. | DRIVER LIC NO. | PHONE NO.

ADDRESS (IF DIFFERENT THAN ABOVE) | CITY | STATE | ZIP CODE

I, the undersigned, being the patient or parent/legal guardian/person having legal custody/or person having legal authorization to consent, freely give my consent to **Brea Urgent Care (BUC)** , and their agents, to examine and treat the patient registered/referenced above. I authorize **BUC** to release any medical records that may be requested by a 3rd party for the purpose of paying for services rendered, and further authorize the payment from any such medical benefits be made directly to **BUC** .

By using insurance for this and other visits, I understand it is my responsibility to know the terms and conditions of my coverage and to provide a copy of the most current insurance card. I know I have the right to decline treatment recommended by the provider. If I am provided service that is not covered by my insurance, or if my insurance coverage has lapsed, I will be responsible for the charge in full. I understand that if my insurance has not paid after 45 days from the billing date that I will be billed directly.

By signature below or acceptance of services, I am fully aware that I am financially responsible for all services provided for me by **Brea Urgent Care** . If I am using insurance, I understand **BUC** will bill my insurance and accept as payment in full the amount the insurance pays, with the exception of co-pays, deductibles, amounts designated as patient responsibility by the insurance, or non-covered services. I also understand that **BUC** reserves the right to bill at a later date for any missed charges for the date of service.

Signature of patient/parent or legal guardian _____ Date: _____