



CityDoc

uptown
urgent care

Reason For Your visit:					
Who referred you to our center please:					
<input type="checkbox"/> Friend or Relative	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Radio	<input type="checkbox"/> Drove Past	<input type="checkbox"/> Insurance Company	<input type="checkbox"/> Physician

Last Name:	First:	Middle In:	Date of Birth: / /	Sex: M / F
Address:			Social Security Number:	
City:	State:	Zip	Is this a work related Injury: Y / N	
Home Phone: ()		Cell Phone: ()	Business Phone: ()	
E-Mail:				

PATIENT DEMOGRAPHICS / CONTACT INFORMATION

Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated
Employment Status:	<input type="checkbox"/> Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Student		

Employer Name:		
Street Address:		
City:	State:	Zip:

Responsible Party:	Relationship:	
Street Address:	Phone: ()	
City:	State:	Zip:
Date of Birth:	Social Security Number:	

Emergency Contact Person:	Phone: ()	Relationship:
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FINANCIAL INFORMATION

How will you be paying for today's visit?	<input type="checkbox"/> Debit Card	<input type="checkbox"/> Cash	<input type="checkbox"/> Personal Check	<input type="checkbox"/> Credit Card
<input type="checkbox"/> Private Insurance: (please complete the following)				

Name of Insured:	Social Security Number: - -	Date of Birth: / /
Insurance Company:	Relationship to patient:	
Claims Address:	State:	Zip:
ID Number:	Group Number:	

PLEASE HAND YOUR DRIVER'S LICENSE TO THE SECRETARY ALONG WITH YOUR INSURANCE CARD TO COMPLETE YOUR REGISTRATION.