FM MEDICAL URGENT CARE, INC
REGISTRATION FORM

(Please Print)

Today's date:	**PCP:**

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**(Former name):**	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F

Street address:	**Social Security no.:**	**Home phone no.:** ( )

P.O. box:	**City:**	**State:**	**ZIP Code:**

Occupation:	**Employer:**	**Employer phone no.:** ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:** ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group no.:**	**Policy no.:**	**Co-payment:** $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	**Subscriber's name:**	**Group no.:**	**Policy no.:**

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative	**Relationship to patient:**	**Home phone no.:**	**Work phone no.:**

		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize FM MEDICAL URGENT CARE, INC or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

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