PATIENT REGISTRATION

University of Maryland
Charles Regional Urgent Care

Please fill out completely and legibly

Patient Name Last _____ First _____ MI _____

Gender M / F / Other **Date of Birth** _____ **Reason for Today's Visit** _____

Date Symptoms Started _____ **Primary Care Doctor (Last, First Name)** _____

Is this Related to a Work Accident Y_____ N _____ **Auto Accident** Y_____ N _____ **Other Accident** Y_____ N _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ **Other Phone** _____ **Patient's Marital Status** _____

Patient's Social Security # _____ **Patient's Employer** _____ **Status** (FT, PT) _____

Work Address _____ **Patient's Work Phone** _____ **Occupation** _____

Person to Notify in Case of an Emergency _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Relationship to Patient _____

INSURANCE COVERAGE

PRIMARY Insurance Company _____

Policy/Member # _____

Group # _____

Policy Holder _____

Relationship to Patient _____

Policy Holder DOB _____

Policy Holder Social Security # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Policy Holder Phone _____

Policy Holder Employer _____

Employment Status (FT, PT, Retired) _____

SECONDARY Insurance Company _____

Policy/Member # _____

Group # _____

Policy Holder _____

Relationship to Patient _____

Policy Holder DOB _____

Policy Holder Social Security # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Policy Holder Phone _____

Policy Holder Employer _____

Employment Status (FT, PT, Retired) _____

GUARANTOR/RESPONSIBLE PARTY (IF PATIENT IS UNDER 18)

Person who Brought Patient in Last _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ **Cell Phone** _____ **Social Security #** _____

Relationship to Patient _____ **DOB** _____ **Occupation** _____

Employer _____ **Status** (FT, PT, Retired) _____ **Work Phone** _____

Work Address _____ City _____ State _____ Zip _____

Consent for Services and Disclosure of Patient Protected Information

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of UMCRUC, LLC. I also understand that UMCRUC, LLC may use or disclose any Protected Health Information(PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor/center and agree to pay any balance once my Insurance Plan has processed my claim.

_____ _____

Signature of Patient or Parent/Guardian if Minor | Relationship to Patient | Date