



PATIENT REGISTRATION FORM

Corona Urgent Care

Ph# (951) 549-0900
 Fax# (951) 278-8552
 2071 Compton Ave., Suite 101/102
 Corona, California 92881

Chino Urgent Care

Ph# (909) 613-0100
 Fax# (909) 613-0600
 12555 Central Ave., Suite C
 Chino, CA 91710

Date: _____

NEW

CHANGE

Patients: Please fill out completely and return to the receptionist desk. Thank You!

I. PATIENT INFORMATION			
Patient Name (Last, First)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	D.O.B.: / /
Address	City	State	Zip
Home Phone #: ()	Driver's Lic #:	SS #: -- --	
Cell Phone #: ()			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Email Address	Referred by:	
Patient's Employer:	Work Phone #: ()		
Employer's Address:	City	State	Zip
Emergency Contact Name:	Emergency Phone #: ()		
II. RESPONSIBLE PARTY INFORMATION			
<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other			
Name:	D.O.B.: / /	Phone #: ()	
Employer:	Work Phone #: ()		
Employer's Address:	City	State	Zip
Relationship to Patient:	Drivers Lic #:	SS # -- --	
III. HEALTH INSURANCE INFORMATION			
Name of Insurance Co.:		Name of Insured:	
Claims Address:	City	State	Zip
D.O.B.: / /	SS #: -- --	Relationship to Patient	
Group #:	Policy #:	Phone #: ()	Co-Pay \$:
Secondary Insurance Carrier:	Name of Insured:		
Claims Address:	City	State	Zip
D.O.B.: / /	SS #: -- --	Relationship to Patient	
Group #:	Policy #:	Phone #: ()	Co-Pay \$:
Is This Visit Due To An:	<input type="checkbox"/> ACCIDENT	<input type="checkbox"/> WORK INJURY	<input type="checkbox"/> OTHER
Details of Accident or Injury:			
How will your service be paid today? <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Bill Insurance			

CONCENT: I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I hereby authorize the physician to release any information acquired in the course of my examination or treatment.

Initial: _____

GUARANTEE: I, (the patient or guardian) am an eligible member as of this date of service of a health plan and a copy of the benefits card is attached to this document. Signature of responsible party below acknowledges full financial responsibility for services rendered to me if it is determined I am "Not Eligible" on the date of service in question, or if service rendered is determined to be a non-covered benefit under the plan provisions.

Initial: _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby irrevocably authorize payment directly to the above named corporation/physician, benefits otherwise payable to me but not to exceed the corporation's/physician's regular charge due as a result of this claim. I understand I am financially responsible to the corporation/physician for charges not covered.

Initial: _____

Signed: _____ **Date:** _____ **Relationship to Patient:** _____

Staff Initial: