URGENT+CARE
Hunt Regional Medical Partners

PATIENT CHECK-IN FORM

Please print clearly.

TODAY'S VISIT INFO
Reason for Visit/Symptoms:
Has the Patient been treated for above recently? [ ]No [ ]Yes when _____
Is this work related? [ ]Yes [ ]No Is this from a motor vehicle accident (car, motorcycle, ATV)? [ ]Yes [ ]No

PATIENT INFORMATION		
Last Name:	**First Name:**	**MI:**
Social Security #:	**Date of Birth:**	**Sex: [ ]M [ ]F**
Physical Address- City:	**State:**	**Zip:**
Mailing Address- City:	**State:**	**Zip:**
Telephone #- Home:	**Cell:**	**Other:**
Marital Status: [ ]Single [ ]Married	**[ ]Widowed [ ]Divorced**	
Ethnicity: [ ]Not Hispanic or Latino	**[ ]Hispanic or Latino**	
Race: [ ]American Indian/Alaska Native [ ]Asian	**[ ]Black/African American**	**[ ]White/Caucasian**
[ ]Native Hawaiian/Other Pacific Islander	**[ ]Other Race**	
Email Address:		
Employer Name:	**Work #**	
Employer Address:		

EMERGENCY CONTACT INFORMATION	
Name:	**Relation to Patient:**
Address:	**Telephone #**

PARENT/GUARDIAN INFORMATION *(if patient is under 18)*	
Name:	
Date of Birth:	**Social Security #:**
Employer:	**Work #:**
Employer Address:	

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Policy Holder:	**Policy Holder :**
Date of Birth:	**Date of Birth:**
Social Security #:	**Social Security #:**
Relation to Patient:	**Relation to Patient:**

_____
Initial

I understand that Urgent Care is not a physician's office and I may be billed at an Urgent Care rate. I also understand that I will be seen by a Physician Assistant or Nurse Practitioner.

_____
Initial

If my treatment today requires lab work to be sent out for further testing, I understand that I may be billed for additional charges.

I acknowledge that the above information is correct and current to the best of my knowledge.

_____ _____

Signature Relationship