LANSING URGENT CARE

Patient Registration Form

Date: _____

NOTIFY THE RECEPTIONIST IMMEDIATELY IF YOU FEEL YOU HAVE A POTENTIALLY LIFE THREATENING SYMPTOM OR INJURY

General Information – **NOTE: STUDENTS – PLEASE ONLY INCLUDE PERMANENT ADDRESS BELOW**

Patient First Name: _____ Patient Last Name: _____ **MI:** _____

Gender: ____ Male ____ Female Date of Birth: _____ Social Security Number: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Preferred Method of Contact (circle one): home cell work

E-Mail Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Primary Care Physician: _____ PCP Phone: _____ PCP Fax: _____

Would you like to Opt-In to receive billing statements electronically? ____Yes ____ No

If yes, please provide your Confidential Email Address: ☐ Check if same as above _____

Insurance Subscriber Information (Primary Card Holder Information) – Add Secondary Insurance on back of this page

☐ *If same as above check this box and go to the next section*

Relationship to Patient: _____

Subscriber Name: _____ Subscriber's Date of Birth: _____

Subscriber's Address: _____
Street Address City State Zip

Subscriber's Social Security Number: _____ Insurance Co-pay Amount: $ _____

Reason for Visit

Reason for Visit: _____

A: Is this a work related injury: ____ Yes ____No *If you answered YES to A, please fill out the back of this page*

B: Is this visit Auto Accident Related: ____ Yes ____No

C: Is this visit related to another accident: ____ Yes ____No Accident State: _____ Accident Date: _____

Responsible Party Information - This section only needs to be filled out if the patient is a minor or dependent

* The Responsible Party is the adult who presents for treatment. In the case of a minor it is the adult that accompanies the patient for treatment or who signed the Authorization to Treat Minor Form

Responsible Party Name*: _____ Relationship to Patient: _____

Social Security Number: _____ Date of Birth: _____ Gender: ____ M ____ F

Address: _____ Phone: _____
Street Address City State Zip

How did you hear about Lansing Urgent Care?

_____Billboard _____Phone Book _____Event _____Insurance _____LUC Website

_____Clinic Sign _____Friend/Relative _____Doctor _____Employer _____Facebook/Twitter

_____Internet _____Television _____Radio _____Movie Theater _____Other

FORM CONTINUED ON BACK OF THIS PAGE, PLEASE COMPLETE

LANSING URGENT CARE

Date: _____

Visit Follow-Up Communication

In order to enhance your care and experience at Lansing Urgent Care, we would like to contact you after your visit in order to request feedback by phone or SMS text message. By signing below you understand and agree to be contacted in this manner with communications related to this visit, and any future visits.

In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you.

_____ _____

Patient/Guardian Signature Date

Employer Information – Section only required for work related illness or injuries.

Employer Name: _____

Contact Name: _____ Contact Department: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Employer Phone: _____ Extension: _____ Employer Fax: _____

If Injury, Date of Injury: _____ Claim Number (if applicable): _____

Secondary Insurance Information (Primary Card Holder Information)

☐ *If same as patient name check this box and do not complete this section*

Relationship to Patient: _____

Insurance Card Holder: _____

Last Name *First Name* *M.I.*

Insured's Address: _____

Insured's Social Security Number: _____ Insured's Date of Birth: _____

Thank you for choosing Lansing Urgent Care, it is our pleasure to serve you!