

Lansing Urgent Care
Patient Registration Form

Date: _____

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

Section 1. General Information – NOTE: STUDENTS – PLEASE ONLY INCLUDE PERMANENT ADDRESS BELOW

Pt Last Name: _____ Pt First Name: _____ MI: _____
Gender: _____ Male _____ Female Date of Birth: _____
Social Security Number: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Preferred Method of Contact (circle one): home cell work
E-Mail: _____ Primary Care Physician: _____
Emergency Contact: _____ PCP Phone: _____
Emergency Contact Phone: _____ PCP Fax: _____

Section 2. Insurance Information (Primary Card Holder Information) – Add Secondary Insurance in Section 7

If same as above check this box and go to section 3 Relationship to Patient: _____
Insurance Card Holder: _____
Last Name First Name M.I.
Insured's Address: _____
Street Address City State Zip
Insured's Social Security Number: _____ Insured's Phone: _____
Insured's Date of Birth: _____ Insured's Employer: _____

Section 3. Reason for Visit & Co Pay Information- Note: We DO NOT treat patients involved in Motor Vehicle Accidents

Reason for Visit: _____ Insurance Co-pay Amount: \$ _____

A: Is this visit work related: _____ 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 *If you selected YES to B, please see Receptionist*

C: Is this visit related to another accident*: _____ Yes _____ No

**If you answered yes to C, please answer the following:* Accident State: _____ Accident Date: _____

Section 4. Guarantor* Information - This section only needs to be filled out if the patient is a minor or dependant

*The Guarantor 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

Guarantor's Gender: _____ Male _____ Female

Guarantor*: _____
Last Name First Name M.I.

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

Guarantor's Address: _____
Street Address City State Zip

Guarantor's Phone: _____ Relationship to Patient: _____

FORM CONTINUED ON BACK OF THIS PAGE, PLEASE COMPLETE

