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 Legal First Name: _____ Patient Last Name: _____ MI: _____

Gender at Birth: ☐ Male ☐ Female Date of Birth: _____ Social Security Number: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander
☐ White ☐ Other Race ☐ Decline to specify

Street Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

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

Confidential E-Mail Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Primary Care Physician: _____ PCP Phone: _____ PCP City/State: _____

Patient Preferred First Name: _____

Current Gender Identity: ☐ Male ☐ Transgender Male/Trans Man/Female-to-Male (FTM) ☐ Other: _____
☐ Female ☐ Transgender Female/Trans Woman/Male-to-Female (MTF) ☐ Declined to Specify

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*

Visit Information

Reason for Visit (Please list symptoms): _____

Is this a work related injury: ☐ Yes ☐ No

Is this visit Auto Accident Related: ☐ Yes ☐ No

On a scale from 0-10, where 0 means no pain and 10 means the most or worst pain imaginable, how much pain do you have right now? _____

Do you require a language accommodation or an interpreter to communicate during your visit? ☐ Yes ☐ No

If Yes, What language do you speak? Or what kind of assistance can we provide? _____

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

*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: _____

Address: _____ Phone: _____
Street Address *City* *State* *Zip*

How did you hear about Lansing Urgent Care?

☐ Billboard ☐ Phone Book ☐ Event ☐ Insurance ☐ Postcard- Direct Mail
☐ Clinic Sign ☐ Friend/Relative ☐ Doctor ☐ Employer ☐ Other
☐ Internet ☐ Television ☐ LUC Website ☐ Facebook/Twitter

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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!