Lowcountry Urgent Care

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ MI: _____

Birthdate: _____ SSN: _____ Gender (please circle): Male Female

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Marital Status: _____

Employer Name: _____

Address: _____ City: _____ St: _____ Zip: _____

Employer Phone: _____

Reason for today's visit: _____

How did you hear about us? _____

Primary Physician's Name: _____

Insurance: _____ CoPay: _____

Insured Name: _____ Relationship: _____

Address: _____ City: _____ St: _____ Zip: _____

Birthdate: _____ SSN: _____ Gender: _____

Employer Name: _____

Address: _____ City: _____ St: _____ Zip: _____

(please complete this section if patient is under 18)

Guarantor Name: _____ Relationship: _____

Address: _____ City: _____ St: _____ Zip: _____

Birthdate: _____ SSN: _____ Gender: _____

Employer Name: _____

Address: _____ City: _____ St: _____ Zip: _____

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