Rapid Care Medical Clinic

REGISTRATION FORM

(Please Print)

CASH

Today's date:	PCP: Rapid Care Medical Clinic

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss. ☐ Ms.	Marital Status Single / Mar / Div / Sep / Wid

Are yo allergic to any medicine? ☐ yes ☐No	If so, what medicine?	Are you over 18 yr old?	Birh Date: / /	Age:	Sex: ☐ M ☐ F

Street Address:	Social Security no.:	Home phone.: ( )

Apt #:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone: ( )

Chose clinic because /Referred to clinic by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

RESPONSIBLE PARTY (IF UNDER 18 YRS OLD)

Name of the Responsible party:	Birth Date: / /	Address (if diferent)	Home phone.: ( )

It this person a patient here? ☐ yes ☐No	If No, who was the physician?

Occupation:	Employer:	Employer Address:	Employer phone number.: ( )

REASON FOR OFFICE VISIT

Please indicate primary reason for visiting	☐ Cold	☐ Aches and pain	☐ Vaccination	☐ Pap Smear	☐ Mammogram

☐ Physical Exam	☐ Lawyer Referral	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. If you do NOT have health Insurance. You are expected to pay your balance in full at the time that service are rendered.

Patient/Guardian signature

Date