

# ARLINGTON URGENT CARE

601 S. Carlin Springs Rd.

Arlington, VA 22204

## PATIENT REGISTRATION FORM

DATE: \_\_\_/\_\_\_/\_\_\_

### PATIENT INFORMATION:

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

AGE: \_\_\_\_\_ SEX: (Please circle) M/F MARITAL STATUS: (Please circle) M S D W O

ADDRESS: \_\_\_\_\_ APT #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

PHONE: Home: ( ) \_\_\_\_\_ WORK: ( ) \_\_\_\_\_

CELL PHONE: ( ) \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

PHONE #: ( ) \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

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### IF PATIENT IS A MINOR:

PARENT/GUARDIAN NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS IF DIFFERENT: \_\_\_\_\_ PHONE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

### SECTION A: Medical Insurance Information (If this is a work related injury please skip section A and go to section B)

**PRIMARY COVERAGE:** Please complete the insurance information where indicated below.

INSURANCE COMPANY NAME: \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

**SUBSCRIBERS'S INFO:** NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ EMPLOYER \_\_\_\_\_

RELATIONSHIP TO PATIENT (Please circle one) SELF/SPOUSE/PARENT/OTHER

**SECONDARY COVERAGE:** Please fill out the insurance information where indicated below.

NAME OF INSURANCE COMPANY: \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

**SUBSCRIBERS'S INFO:** NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ EMPLOYER \_\_\_\_\_

RELATIONSHIP TO PATIENT (Please circle one) SELF/SPOUSE/PARENT/OTHER

**OVER →**

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## SECTION B: WORKERS COMPENSATION INFO:

### ONLY COMPLETE THIS SECTION IF YOU ARE HERE FOR A WORK RELATED INJURY.

NAME OF EMPLOYER: \_\_\_\_\_

EMPLOYERS ADDRESS: \_\_\_\_\_

MANAGER'S NAME: \_\_\_\_\_ PHONE Number: (     ) \_\_\_\_\_

DATE OF INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME OF WORKERS'S COMPENSATION CARRIER: \_\_\_\_\_

ADJUSTOR'S NAME: \_\_\_\_\_ PHONE #: (     ) \_\_\_\_\_

ADDRESS FOR CLAIM SUBMISSION: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CLAIM NUMBER: \_\_\_\_\_

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### **SIGNATURE: All patients or responsible parties must read and acknowledge by signing below.**

I hereby authorize payment directly to Arlington Urgent Care from my insurance company for the surgical and/or medical benefits, if any, otherwise payable to me or on my behalf for services furnished to me. I authorize Arlington Urgent Care to release any information for an unlimited time for insurance purposes required in the course of my examination or treatment, which shall include HIV, communicable disease or drug abuse information. My signature below also indicates that I am providing accurate, current insurance and demographic information. I understand that I am financially responsible for the charges not covered by my insurance and all balances due as a result of partial or non-covered charges, treatments and supplies/equipment. I understand that if Arlington Urgent Care does not participate with my plan, or I am un-insured I will be responsible for all charges incurred. I also understand these charges, co-pays, deductibles and balances due are payable at the time of service. I agree to pay reasonable attorney's fees and court costs if debt collection is necessary in the event my account is delinquent. I also agree to pay a \$35.00 service charge in the event that my check is returned from the bank.

With my signature, I also acknowledge the receipt and content of the NOTICE OF PRIVACY PRACTICES.

\_\_\_\_\_  
Signature (Patient or Parent if Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Relationship: (circle)  
Self / Parent / Guardian