PATIENT REGISTRATION & INFORMATION

ERgent Med
IMMEDIATE AND PRIMARY CARE

TODAY'S DATE:	
FULL LEGAL NAME :	
DATE OF BIRTH:	**GENDER:**
SSN:	**RACE:**
MARITAL STATUS: MARRIED SINGLE DIVORCED [CIRCLE ONE]	
HOME ADDRESS: _____ STREET ADDRESS _____ CITY STATE ZIP	
CELL PHONE:	**HOME PHONE:**
EMAIL ADDRESS:	
Is it OK for us to contact you via Email using the above provided E-mail address? ☐ **YES** **OR** ☐ **NO**	
How did you hear about us?	
PHARMACY [LOCAL]:	**MAIL ORDER PHARMACY:** * IF APPLICABLE
PHARMACY LOCATION:	
PHARMACY PHONE #:	* PLEASE ATTACH MAIL ORDER PHARMACY INFO FOR E-PRESCRIBING:

If patient is a minor, list the financially responsible individual's name and address here:

_____ NAME of Financially Responsible Person

_____ Mailing Address for Financially Responsible Person

HEALTH INSURANCE INFORMATION

* ERgent Med is happy to file your insurance for services rendered if we are in network with your policy. It is your responsibility to provide us with the most recent and up to date insurance cards and ensure that the policy holder information is acurate, or we will not be able to file the insurance correctly and you may risk receiving a bill that could otherwise be avoided. We ALSO MUST HAVE COPIES OF ALL of your INSURANCE CARDS!!!

* If you have a Medicare Replacement Insurance [ie: Aetna Medicare, Humana, United Healthcare Medicare Advantage, etc] , then the Medicare Replacement is your PRIMARY insurance. We will need a copy of BOTH the Medicare Replacement Insurance card AND your Medicare Orginal card.

PRIMARY HEALTH INSURANCE:	
MEMBER ID / POLICY #:	**GROUP #:**
NAME OF POLICY HOLDER:	**POLICY HOLDER'S RELATIONSHIP TO PATIENT:** PARENT SPOUSE [CIRCLE ONE] OTHER
POLICY HOLDER'S DATE OF BIRTH:	
POLICY HOLDER'S MAILING ADDRESS:	

SECONDARY HEALTH INSURANCE:	
MEMBER ID / POLICY #:	**GROUP #:**
NAME OF POLICY HOLDER:	**POLICY HOLDER'S RELATIONSHIP TO PATIENT:** PARENT SPOUSE [CIRCLE ONE] OTHER
POLICY HOLDER'S DATE OF BIRTH:	
POLICY HOLDER'S MAILING ADDRESS:	

EMPLOYMENT INFORMATION:						
STATUS:	FULL TIME	PART TIME	DISABLED	RETIRED	UNEMPLOYED	STUDENT
PATIENT'S EMPLOYER:				WORK PHONE:		

EMERGENCY CONTACT INFORMATION		
NAME:		RELATIONSHIP :
DATE OF BIRTH:		
CELL PHONE:		WORK PLACE:
HOME PHONE:		WORK PHONE:

I have voluntarily provided the above information and authorize ERgent Med and it's representatives to contact the above listed emergency contacts and discuss my pertinent health related information on my behalf in the event of an emergency.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARDIAN SIGNATURE [If applicable]: _____ **Relationship to patient:** _____ **DATE:** _____