HEARTLAND URGENT CARE

965 S 27th Street, Suite D
Lincoln, NE 68510

PATIENT REGISTRATION FORM

Patient Information

Full Name: _____ Age: _____ DOB: _____-_____-_____ **Male** or **Female**

Address: _____ **APT #**:_____ City: _____ State: _____ Zip: _____

Home Phone: **(_____)** _____-_____ Cell Phone: **(_____)** _____-_____ Soc Security #: _____-____-_____

Race: ***(Please check one)***

◯ *American Indian/Alaska Native*
◯ *Asian*
◯ *Black or African American*
◯ *Native Hawaiian or other Pacific Islander*
◯ *White*
◯ *Decline to Specify*

Ethnicity: ***(Please check one)***

◯ *Hispanic or Latino*
◯ *Not Hispanic or Latino*
◯ *Decline to Specify*

Marital Status: (Please check one)

◯ *Single* ◯ *Partnered*
◯ *Married* ◯ *Widowed*
◯ *Divorced*

Primary Language Spoken_____

Primary Care Physician Name or Group: _____ No PCP ◯

Parent/Guardian Information/Financially Responsible Party *(for patients under 19 years of age)*

Full Name: _____ Age: _____ DOB: _____-_____-_____ **Male** or **Female**

Address: _____ **APT #**:_____ City: _____ State: _____ Zip: _____

Home Phone: **(_____)** _____-_____ Cell Phone: **(_____)** _____-_____ Soc Security #: _____-_____-_____

Relationship to Minor/Patient: Mother ☐ Father ☐ Grandparent ☐ ☐ Other: _____

Please list a preferred pharmacy so that we may send out any prescriptions electronically

Pharmacy Name (please add location)_____

Emergency Contact Information (Person *NOT* living in the same household)

Full Name: _____ Relationship: _____
Home Phone: **(_____)** _____-_____Cell Phone: **(_____)** _____-_____Work Phone: **(_____)** _____-_____

Primary Insurance Policy Holder Information **All Information is required*

Please be aware that if you do not provide all required information, we will not be able to file properly with your insurance company and you will be responsible for the visit.

Insurance Name: _____
Policy Holder's Full Name: _____ **Policy Holder's DOB:** _____-_____-_____
Policy Holder's Address: _____ **APT #**_____ **City:** _____ **State:** _____ **Zip:** _____
Policy Holder's Social Security #: _____-_____-_____ **Policy Holder's Phone Number: (_____)** _____-_____
Policy Holder's Employer: _____ **(Please Circle) Male or Female**

Relationship to Insured: Self ☐ Spouse ☐ Child ☐ ☐ Other: _____

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Secondary Insurance Policy Holder Information **All Information is required**

Please be aware that if you do not provide all required information, we will not be able to file properly with your insurance company and you will be responsible for the visit.

Insurance Name: _____

Policy Holder's Full Name: _____ Policy Holder's DOB: _____-_____-_____

Policy Holder's Address: _____ APT #_____ City: _____ State: _____ Zip: _____

Policy Holder's Social Security #: _____-_____-_____ Policy Holder's Phone Number: (_____) _____-_____

Policy Holder's Employer: _____ (Please Circle) Male or Female

Relationship to Insured: Self □ Spouse □ Child □ Other: _____

How did you hear about us?: (Please check all that apply)

❑ Family ❑ Friend ❑ Co-Worker ❑ Phone book/yellow pages ❑ Employer ❑ Saw building/sign

❑ Internet Search ❑ Referred by my PCP ❑ Flyer/Magnet ❑ Prior Visit

❑ Newspaper or other publication ❑ Other (Please explain) _____

Please continue to Health History on next page