AllBetterCare
Urgent Care Center

REGISTRATION FORM

(PLEASE PRINT)

Today's Date:	Have you been here before? ☐ Yes ☐ No	Family Doctor:
Reason for visit:		Preferred Pharmacy:
Is this work related? ☐ Yes ☐ No	If yes, please list company and supervisor's name:	

PATIENT INFORMATION

Patient's First Name:	Last:		Middle:
Birth Date:	Gender: ☐ Female ☐ Male		
Race/Ethnicity: ☐ African American ☐ Caucasian ☐ Asian/Pacific Islander ☐ Spanish/Hispanic Origin ☐ Decline			
Street Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
Social Security #:	Employer Name:		

☐ YES! Sign me up for the AllBetterCare Newsletter to receive free emails announcing our upcoming events, contests, and tips.

Chose clinic because/referred to clinic by (Please check one): ☐ Dr. Referral ☐ Insurance Plan ☐ Clinic Sign ☐ Billboard ☐ Newspaper/Magazine ☐ School ☐ Family/Friend ☐ Google Search ☐ PennLive ☐ Cumberlink ☐ Direct Mail ☐ Been Here Before

PLEASE GIVE INSURANCE CARD TO RECEPTIONIST

Is the patient covered by insurance? ☐ Yes ☐ No	**Is the patient the policy holder?** ☐ Yes ☐ No If no, please complete
Policy Holder's Name:	Secondary Ins (if applicable):
Policy Holder's Birth Date:	DOB:
Patient's relationship to Policy Holder:	Relationship:
Address (if different):	Address (if different):

IN CASE OF EMERGENCY

In case of emergency, may we contact this person regarding your medical care? ☐ Yes ☐ No		
Name of emergency contact:		
Relationship to patient:	Home Phone:	Work Phone:

Are you the responsible financial party for any personal balances due? ☐ Yes ☐ No **If no, please complete.**

Name:

Address: **Telephone Number:**

With my electronic signature, I attest that the above information is accurate and true to the best of my knowledge. I have read, understood, and agree with the AllBetterCare HIPAA, privacy, treatment, and payment policy. I authorize my insurance benefits to be paid directly to the physician for any treatment directed or rendered by AllBetterCare. I understand that I am financially responsible for any balance. I also authorize AllBetterCare or insurance company to release my information required to process my claims.

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