

**Patient Registration Form**

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| |  |  | | --- | --- | | Today’s Date: | Primary Doctor: |  PATIENT INFORMATION  |  |  |  |  | | --- | --- | --- | --- | | First Name: | Last Name: | Middle Name: | Date of Birth:  Age: |   Address: **EMAIL:**   |  |  |  | | --- | --- | --- | | Social Security number: | Home phone number: | Cell phone number: | |  |  |  | | Occupation: | Insured: Yes No | Name of Insurance Company: | |  |  |  |  IN CASE OF EMERGENCY  |  |  |  |  | | --- | --- | --- | --- | | Name: | Relationship to patient: | Home phone number: | Work phone number: | |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  | Patient/Guardian signature |  | Date |  | |
| **How did you hear about Xcel Urgent Care?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |