**Patient Registration Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| 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 |  |

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| **How did you hear about Xcel Urgent Care?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |