XCEL URGENT CARE

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 _____

How did you hear about Xcel Urgent Care? _____