Channel Islands Family Practice and Urgent Care
2103 Pickwick Dr.
Camarillo, CA 93010

Patient Registration Information

Name_____ Social Security _____
Date Of Birth _____ Age _____ Marital Status: Single____ Married____ Divorced____
Address _____Atp_____ City _____ State ____ Zip_____
Home Phone # _____Cell Phone #_____

Employed by _____ Phone # _____
Address _____
Who to Notify in Case Of Emergency? _____ Phone# _____
Email Address: _____(for important medical Information)

Responsible Party for Payment

Name _____ Social Security # _____
Address_____apt_____ City_____State___Zip _____
Relationship to patient _____ Phone # _____
Employed by _____ Phone # _____

Medical Insurance Information (primary card holder information)

Insured Name _____ Date of Birth_____
Insured Social Security #_____Relationship with patient _____
Insurance Company _____Phone#_____
Address_____City_____State_____Zip_____
Policy/Subscriber# _____ Group # _____

Please Sign and Return to Receptionist

I, the undersigned, have insurance coverage with, _____ and assign directly to Channel Islands Urgent Care all surgical and medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also agree that I will be charged a $15.00 late fee every 30 days that my balance goes unpaid. I hereby authorize the doctor to release all information necessary in accordance with the **Hippa Privacy Act (a complete copy available for you to review),** to secure the payment of benefits. The undersigned gives consent for treatment.

_____ _____
Date Patient / Responsible Party