Atlantic Health System
Immediate Care

PATIENT REGISTRATION FORM

PATIENT DATA

PATIENT LAST NAME **FIRST** **MI** [ ] FEMALE [ ] MALE BIRTH DATE AGE HOME PHONE

ETHNICITY
[ ] WHITE/NON HISPANIC [ ] BLACK/AFRICAN AMERICAN [ ] AMERICAN INDIAN OR ALASKAN NATIVE
[ ] HISPANIC [ ] ASIAN OR PACIFIC ISLANDER [ ] OTHER_____

ADDRESS SOCIAL SECURITY NO. MARITAL STATUS S M W D CELL PHONE

CITY STATE ZIP ARE YOU EMPLOYED? [ ] YES [ ] NO EMPLOYER NAME OCCUPATION

EMPLOYER ADDRESS WORK PHONE

WHO CAN WE CONTACT IF WE ARE UNABLE TO REACH YOU? RELATIONSHIP PHONE

PERMISSION TO RELEASE MEDICAL INFORMATION TO RELATIONSHIP

INSURANCE

INSURANCE COMPANY PRIMARY **EFFECTIVE DATE**

POLICY/ID # GROUP # PHONE

POLICY HOLDER

SS #

DATE OF BIRTH SEX

RELATIONSHIP TO PATIENT

INSURANCE COMPANY SECONDARY

POLICY/ID # GROUP # PHONE

POLICY HOLDER

SS #

DATE OF BIRTH SEX

RELATIONSHIP TO PATIENT

WORKERS COMP.

HOW DID INJURY OCCUR? **DATE OF INJURY** **DOES YOUR EMPLOYER KNOW?**
[ ] WORK [ ] MVA [ ] OTHER [ ] YES [ ] NO

IF WORKERS COMP., INS. CARRIER NAME & ADDRESS (WHERE TO SEND CLAIMS) CITY, STATE, ZIP PHONE

EMPLOYER NAME & ADDRESS: (WHEN INJURY OCCURRED) CITY, STATE, ZIP INJURY CLAIM # EMPLOYER POL #

MVA

IF MVA, INS. CARRIER NAME AND ADDRESS **INJURY CLAIM #**

PHARMACY NAME

ADDRESS

PHONE

PRIMARY CARE PHYSICIAN

ADDRESS

PHONE

A summary of your visit will be sent to your Primary Care Physician

REASON FOR VISIT

EMAIL ADDRESS *

☐ **Yes, I would like to receive Immediate Care news & emails**

HOW DID YOU HEAR ABOUT US? (CIRCLE ONE) FRIEND/FAMILY IMMEDIATE CARE STAFF PHYSICIAN REFERRAL EMPLOYER
COMMUNITY EVENT SOCIAL MEDIA DIRECT MAIL PRINT AD RADIO BILLBOARD DIGITAL AD OTHER:_____

PATIENT SIGNATURE x **DATE**