Patient Registration

Patient Last Name _____

Patient First Name _____ Middle Initial _____

Social Security Number _____ Date of Birth _____

Gender: ☐ Male ☐ Female Race: _____ Ethnicity: _____

Preferred Language: _____

Street Address _____

City _____ State _____ Zip _____

Home Telephone _____ Mobile Telephone _____

E-mail (optional) _____ Marital Status _____

Patient Employer _____

Primary Care Physician _____

Insurance _____ Insurance Co-pay amount $ _____

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Insurance Card Holder / Guarantor: _____
Last Name First Name M.I.

Guarantor's Street Address _____

Guarantor's City _____ State _____ Zip _____

Guarantor's Phone # _____

Guarantor's Social Security Number _____ Date of Birth _____

Gender: ☐ Male ☐ Female Relationship to Patient: ☐ Parent ☐ Spouse

Guarantor's Employer Address _____

Where did you hear about MEDIQ Urgent Care?
☐ Relative ☐ Friend ☐ Mailer ☐ Signage ☐ Work ☐ Radio ☐ TV ☐ Other _____