SandBay PRIMARY + URGENT CARE

"Better health now & wellness for life"

REGISTRATION FORM

(Please Print)

REASON FOR YOUR VISIT: ☐ **AUTO** ☐ **WORK RELATED**

Today's Date:	Requested Pharmacy:

PATIENT INFORMATION

Patient's last Name:		☐ Mr. ☐ Mrs.	Marital Status:
First:	Middle Initial:	☐ Miss ☐ Ms.	Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal Name? ☐ Yes ☐ No	If not, what is your Legal Name?	(Former Name):	D.O.B (Mo/Day/Year):	Age:	Sex: ☐ M ☐ F

Street Address:	Social Security : _ _	☐ Home Phone: ☐ Cell Phone: ( )
		E-mail:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone: ( )

Chose clinic because/referred to clinic by (Please check one box)

☐ Ad/Sign ☐ Insurance plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages

☐ Our Website ☐ Provider Referral: ☐ Other:

Has any other family members been seen here? ☐ Yes ☐ No

Race Ethnicity (Please check box below)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific ☐ Black or African American ☐ White

☐ Hispanic ☐ Other

Ethnicity (Please check boxes below)

☐Hispanic or Latin ☐ Not Hispanic or Latin ☐ Refuse to respond

Language

☐ English ☐ Indian(Include Hindi and Tamil) ☐ Spanish ☐ Vietnamese ☐ Sign language ☐ Other

CONTACT IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Patient:	Home Phone: ( )
		Work Phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for my balance. I authorized SandBay Family & Urgent Care and/or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*