REGISTRATION FORM

Today's Date:	PCP:		
PATIENT INFORMATION			
Patient's Last Name:	First:	MI:	
Birth Date:	Age:	Sex: ❑ M ❑ F	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Street Address:	Social Security Number:	Home Phone Number: ( )	
P.O. Box:	City:	State:	Zip Code:
Employer:	Work Injury: ❑ Yes ❑ No	Employer Phone Number: ( )	
Referred By: ❑ Yellow Pages ❑ Mailer ❑ Magazine ❑ Newspaper ❑ Radio ❑ Hospital ❑ Physician ❑ Insurance ❑ Employer ❑ GIC Employee ❑ Family/Friend ❑ Close to Home/Work ❑ Other			
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Relationship:	Date of Birth:	
Address (if different):			
Social Security Number:	Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Employer:			
Is this patient covered by Insurance? ❑ Yes ❑ No	Covered by Worker's Compensation: ❑ Yes ❑ No		
IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship:	Home/Cell Phone: ( )	Work Phone: ( )

I consent to the examination, treatment and procedures which may be performed during this visit, including emergency treatment deemed necessary by Guilford Immediate Care staff. I understand that the examination I am about to receive should not be considered to be in lieu of my ongoing and preventative health care needs, which should be provided by my personal physician. I also authorize the release of information requested by my insurance company and the release of my medical records (current and historical) to health care providers with whom I or my treatment physician(s) may consult for medical treatment.

Signature of Patient and/or Legal Guardian or Parent:	Date: