Registration Form

Patient Information

Patient's Name	
Date of Birth	
Social Security Number	
Driver's License Number	
Home Address	
City, State, Zip code	
Home Phone Number	
Cell Phone Number	
Email Address	
Occupation & Employer	
Work Address	
City, State, Zip Code	
Work Phone Number	

Insurance Subscriber Information

Subscriber Name & Relationship	
Date of Birth	
Social Security Number	
Insurance Company Name	
Subscriber ID and Group Number	

Emergency Contact Information

Emergency Contact Name	
Relationship to Patient	
Home Phone Number	
Cell Phone Number	

If the Patient is a Minor:

Parent/Guardian's Name(s)	
Date of Birth	
Social Security Number	
Driver's License Number	
Home Phone Number	
Cell Phone Number	

Consent for the Use and Disclosure of Protected Health Information (please circle):

Wise Family Practice Urgent Care Center may call my home/cell and leave a message or voicemail in reference to any terms that assist in the practice of carrying out treatment, payment or health care operations, such as appointment reminders, insurance items and any call pertaining to my clinical care including diagnostic results among others.	Yes / No
Wise Family Practice Urgent Care Center may mail to my home or other designated location any items that may assist the practice of carrying out treatment, payment or health care operations, results of labs/studies, or insurance statements.	Yes/ No
***I allow Wise Family Practice Urgent Care to discuss my medical information with: Name: ________________________________ Relationship:___________________________________ Name: ________________________________ Relationship:___________________________________	

By signing this form, I am acknowledging that I have received the Notice of Privacy Practices, and I consent to Wise Family Practice Urgent Care's use and disclosure of my personal health information to carry out treatment, payment or health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patient/ Guardian Signature ____ **Date** ________________