Doylestown Health
URGENT+CARE

Patient Registration Form

Date: _____

Patient Information

Patient Name: _____

Date of Birth: _____ Gender: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Marital Status: _____ Preferred Language: _____ Race: _____

Ethnicity: Hispanic or Latino | Not Hispanic or Latino | Prefer Not to Answer

How did you hear about us? _____

Pharmacy Information

Preferred Pharmacy: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Pharmacy Phone: _____

Insurance Information on Back

Insurance Information

Insurance Company: _____

Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber SSN: _____

Relationship to Patient: _____

Policy #: _____ Group #: _____

Secondary Insurance Name: _____

Subscriber Name: _____ Date of Birth: _____

Responsible Party *(If patient is not financially responsible for account)*

Responsible Party Full Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

Motor Vehicle Accident *(If this visit is a result of a motor vehicle accident, the following information is required)*

Auto Insurance Company: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Claims Adjuster / Contact: _____ Phone: _____

Policy Holder's Name: _____ Birthdate: _____

Claim Number: _____

X: _____ Date: _____
   Signature of Patient or Guarantor

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