CAPE REGIONAL
URGENT CARE

PLEASE CLEARLY PRINT ALL PATIENT INFORMATION

TODAY'S DATE: _____ REASON FOR TODAY'S VISIT: _____

WORK RELATED: YES or NO MOTOR VEHICLE INJURY RELATED: YES OR NO

LAST NAME: _____ FIRST NAME: _____ MI: _____

GENDER: Male or Female BIRTH DATE: _____ SS#: _____/_____/_____

HOME ADDRESS: _____UNIT OR APT # _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____-_____-_____ OK TO LEAVE VOICEMAIL ON HOME PHONE: YES or NO

CELL PHONE #: _____-_____-_____ OK TO LEAVE VOICEMAIL ON CELL PHONE: YES or NO

EMAIL ADDRESS: _____ PRIMARY CARE PHYSICIAN: _____

LOCAL PHARMACY (for today's visit): _____ LOCATION: _____

RACE: _____ HISPANIC OR LATINO: YES or NO PREFERRED LANGUAGE: _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE: _____

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S ADDRESS (if different than patient): _____ UNIT OR APT # _____

CITY: _____ STATE: _____ _____ ZIP: _____

POLICY HOLDER'S BIRTH DATE: _____ POLICY HOLDER'S SS #: _____/_____/_____

SECONDARY INSURANCE: YES or NO IF YES, NAME OF INSURANCE_____

GUARANTOR SECTION – COMPLETE IF PATIENT IS UNDER THE AGE OF 18

GUARANTOR NAME (Person financially responsible): _____ RELATIONSHIP: _____

ADDRESS (if different from patient): _____ UNIT OR APT # _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____-_____-_____ BIRTH DATE: ____/_____/_____ SS # _____

NAME OF PERSON WITH MINOR TODAY _____RELATIONSHIP:_____

PLEASE SIGN AND DATE ON THE REVERSE SIDE