ADVOCATE URGENT CARE

CLINIC REGISTRATION

Student Name (First, Middle, Last): _____

DOB: _____ SSN: _____ Age: _____ Gender: _____ School: _____

Mailing Address: _____

Guardian Phone: _____ Guardian Email: _____

Primary Care Doctor/Clinic: _____ Preferred Pharmacy: _____

Guarantor Name (First, Last): _____Guarantor DOB: _____

Guarantor Mailing Address: _____ Phone: _____

Is the Patient covered by Insurance? YES or NO.

Please fill in all the following below:

Primary Insurance

Name of Insurance Company: _____

Claims Address: _____

Member ID#: _____Group #: _____

Name of Policy Holder: _____ DOB: _____ SSN#: _____

Patient's Relationship to Policy Holder: SELF SPOUSE CHILD OTHER: _____

Secondary Insurance

Name of Insurance Company: _____

Claims Address: _____

Member ID#: _____Group #: _____

Name of Policy Holder: _____ DOB: _____ SSN#: _____

Patient's Relationship to Policy Holder: SELF SPOUSE CHILD OTHER: _____

Parent/Guardian Signature: _____ Date: _____