Patient Registration

Proximity MD URGENT CARE, Inc.
3409 Calloway Drive, Suite 101 Bakerfield, CA 93312
Phone: 661-829-7050, Fax: 661-829-7060, Email: info@proximityhc.com

Patient Name: **DOB:** **Date:**

Address: **Age:** **EMR #:**

Sex: **CHART#:**

Phone Numbers: OK To Leave Message!

(H) _____ ☐ **Driver's LN** _____

(W) _____ ☐ **Social SN:** _____

(C) _____ ☐ **Other ID:** _____

Email: _____

Employer: _____

Address: _____

Zip Code: _____ **Phone:** _____

Position _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment: ☐ Full Time ☐ Part Time ☐ None ☐ Retired ☐ Military ☐ Self Emp

Student Status: ☐ Full Time ☐ Part Time ☐ None

Physician Name: _____

Physician Phone: _____

RESPONSIBLE PARTY (If Minor)

Mother: _____

☐ Same Address as Patient

If Other Address: _____

Zip: _____ Phone: _____

Birth Date: _____ **SSN:** _____

Father: _____

☐ Same Address as Patient

If Other Address: _____

Zip: _____ Phone: _____

Birth Date: _____ **SSN:** _____

EMERGENCY CONTACTS

Relationship: ☐ Parent ☐ Sibling ☐ Relative ☐ Friend

Name: _____ ☐ Other: _____

☐ Same as Patient

Address: _____ **Phone:** _____

City: **State:** **Zip:** **Cell:**

Relationship: ☐ Parent ☐ Sibling ☐ Relative ☐ Friend

Name: _____ ☐ Other: _____

☐ Same as Patient

Address: _____ **Phone:** _____

City: **State:** **Zip:** **Cell:**

Nearest Person (Not Living with You):

Relationship: ☐ Parent ☐ Sibling ☐ Relative ☐ Friend

Name: _____ ☐ Other: _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell:** _____

SPOUSE INFORMATION:

Name: _____

DOB: _____

SSN: _____

Phone: _____

Cell: _____

☐ Same Address as Patient

If Other Address: _____

_____

City: _____

State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance Information:

Insurance A _____

Policy #: _____ Group #: _____

Subscriber: _____ DOB: _____

Subscriber SSN: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father

Subscriber Address Same As: ☐ Self ☐ Spouse ☐ Mother ☐ Father

If Other Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Information:

Insurance B _____

Policy #: _____ Group #: _____

Subscriber: _____ DOB: _____

Subscriber SSN: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father

Subscriber Address Same As: ☐ Self ☐ Spouse ☐ Mother ☐ Father

If Other Address: _____

City: _____ State: _____ Zip: _____

FINANCIAL AGREEMENT

I understand and agree that Proxiity M.D. Urgent Care will bill my insurance as a courtesy.

* If verification of my medical insurance coverage cannot be made at this time, I will receive services today with the understanding that in the event coverage is NOT in effect, I am responsible for any balance on my account.
* If I do not have insurance coverage, I am required to pay for all services rendered to me today; this does not guarantee payment in full and I may still receive a bill for labs and other services provided to me.

I have read and agree to the financial statement, and certify that the above information is correct to the best of my knowledge.

_____ _____

Patient/Guardian Signature: **Date**