Freedom Urgent Care, PLLC
300 W. Central Texas Expressway, Ste 115
Harker Heights, Texas 76548
Patient Registration Form

Today's Date____________________New Pt______Returning Pt______WORK RELATED INJURY______AUTO ACCIDENT______
PRIMARY Dr: ____________________________________Reason for Visit____

Patient Information: *Name____*Age____________________
First MI Last

*D.O.B. ____________________ *SSN#__________________________________ * Sex (circle one) M/ F *Marital Status____________

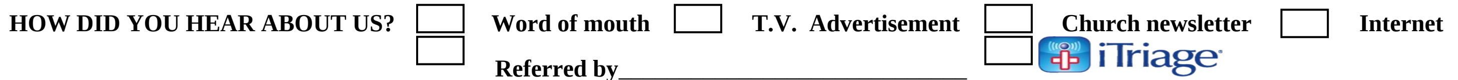
*Address____*City_________________________*State__________*Zip____________

*Home Phone ______________________ *Cell Phone ______________________ *Email ____________________________________

*Preferred Language _______________________*Ethnic Group________________________*Race_____________________________

*Employer ____ *Work Phone____________________

*Employer's Address____*City_______________*State__________*Zip____________



HOW DID YOU HEAR ABOUT US? ☐ **Word of mouth** ☐ **T.V. Advertisement** ☐ **Church newsletter** ☐ **Internet**
☐ **Referred by**____________________________ ☐ iTriage

PARENT OR GUARDIAN: Name: ____*Marital Status__________
Relation to Patient: ☐ Parent ☐ Guardian

DOB: ____________________ SSN# ___________________________________ Cell Phone _______________________________

Address ____ Home Phone _____________________
Street City State Zip

Primary Insurance Name:*____

*Address ____*City, State, Zip ____

*Policy / Pt ID / Member ID____ _*Group # __________________________________

*Policy Holder Name ________________________________Sex (Circle) M/F ____ **Relationship to Patient**_________________________

*DOB: _______________ *SSN# _______________________________________*Cell Phone_____________________________

*Employer____ *Work Phone____________________________

*Employer's Address ____
Street City State Zip

Secondary Insurance Name: ____

*Address ____*City, State, Zip ____

*Policy / Pt ID / Member ID____ _*Group # __________________________________

*Policy Holder Name ________________________________Sex (Circle) M/F ____ **Relationship to Patient**_________________________

DOB: _______________ SSN# _______________________________________Cell Phone______________________________

Authorized signature is on file. By signing, I attest that all information provided is true and correct. I authorize the release of any necessary medical information and payment of medical benefits to the physician for services rendered. I understand and agree that:
1) I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the notice:________
2) I am responsible for all charges incurred including the balance remaining after payment of insurance benefits (as per your insurance contract);
3) Payment is expected on the day services are rendered unless prior arrangements are made; and
4) That the information in this paragraph may not be altered or amended by me.
5) I authorize Freedom Urgent Care to review my personal medication history.

**** All co-pays are due at time of service.** INSURANCE VERIFIED (STAFF INITIAL)___________

****Patient or Responsible Party Signature: ______________________________________ Date __________**

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ____ Date of Birth________________
First name Middle Last Name MM/DD/YYYY

Address:____
Street City State Zip Code Phone #
(________)______________________________

SSN: ____________-_______-__________________

Hereby authorize/request you ***Freedom Urgent Care***
to release confidential information contained in my medical records or the medical record of my child:

____,
First Name MI Last Name DOB

Including but not limited to progress notes, history & physical, radiology reports, lab reports, EEG reports, discharge summaries, medication reports, and consultation reports.

I authorize no limits on dates, history of illness, or diagnostic and therapeutic information, including any dependency, HIV, AIDS and/or other communicable diseases. _________________________ (Initials)

PHI released to: **PLEASE SPECIFY BY LISTING THE NAME(S) OF PERSON OR ORGANIZATION**

Other____

Patient____

Guardian____

Permission is not given______________

_______________________________________ ____________________
Patient/Guarantor's Signature Date

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