Neighborhood Clinic
Registration

Last Name_____ First Name _____ Middle Initial _____

Street Address_____ City_____ State_____ Zip_____

Social Security # _____ Date of Birth _____ Age _____ Sex M / F

Home Phone #_____ Cell #_____ Email _____

Marital Status: (Circle One) Single Married Widowed Separated Divorced Other

Race_____ Ethnicity: Hispanic/Latino Non-Hispanic/Latino

First Emergency Contact:

Name _____ Phone # _____ Relationship _____

Second Emergency Contact:

Name_____Phone # _____Relationship_____

Reason For Visit:

_____
_____
_____
_____

RESPONSIBLE PARTY (If minor)

Last Name _____ First Name _____ Middle Initial_____

Street Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____ Relationship to Patient _____

Home Phone # _____ Work # _____

Primary Insurance Information

Insurance Company _____ Policy Number _____ Group #_____

Name of Subscriber _____ Subscriber's Date of Birth _____

Relationship to Patient _____ Phone # _____

Secondary Insurance Information

Insurance Company _____ Policy Number _____ Group #_____

Name of Subscriber _____ Subscriber's Date of Birth _____

Relationship to Patient _____ Phone # _____

Neighborhood Clinic

Consent for services and/or disclosure of Protected Health Information

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of Neighborhood Clinic. I also understand that Neighborhood Clinic may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of any information concerning me (or my child"s) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand that payment for copay, coinsurance and any other patient amount due to be paid at time of service. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor and agree to pay any remaining balance once my insurance plan has processed my claim.

Accurate prescription history reduces medication errors and enhances patient safety. By authorizing Neighborhood Urgent Care and its Affiliated Providers, to view your external prescription history provides our staff with information about medications you are already taking to minimize the number of adverse drug events. I understand that prescription history from multiple other unaffiliated medical pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years. By signing this consent form you are agreeing that Neighborhood Urgent Care and its Affiliated Providers can request and use your prescription medication history from other healthcare providers.

_____ _____

Patient/Guardian Name Patient Date of Birth

_____ _____

Signature of Patient or Parent/Guardian Date