METRO URGENT CARE, LLC

123 Concord Plaza Shopping Center Saint Louis, MO 63128
Phone: 314-270-9313 Fax: 314- 270-9315

PATIENT REGISTRATION FORM

( ) New Patient ( ) Established Patient / been here before.

Reason for being seen: ____________________

Patient Information:

Last Name: ____________ First Name: ____________ Middle Name / Initial ____________

Birth Date: ____________Age: ____ Sex: ____ Social Security: ____________

Occupation: ____________ Employer: ____________

Employer's Address: ____________

Home Address: ____________ Marital Status: ( ) single ( ) married

City ____________ State ____________ Zip ____________ ( ) divorced ( ) widowed ( ) separated

Home Phone: ____________ Work Phone: ____________ Cell Phone : ____________

Responsible Party:

Insured Name : ____________ First Name :____________ M. I. ____________

Relationship to Patient: ____________ Birth Date ____________ Social Security: ____________

Address:____________ City: ____________ State: ________ Zip: ____________

Primary Insurance: ____________ Secondary Insurance: ____________

Emergency Contact: ____________ Phone: ____________Relationship: ____________

I hereby consent to any medical treatment, lab procedures, surgical procedures, immunization and other services rendered to me or by my legal minor by the Medical Staff of Metro Urgent Care, LLC. I understand that I am fully responsible for all charges whether or not paid by my insurance company. I authorize Metro Urgent Care, LLC to send medical information to my insurance to secure payment of benefits. I also authorize the use of my signature shown below on all insurance submissions and as authorization for payment to be sent to Metro Urgent Care, LLC.

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Responsible Party Signature **Relationship** **Date**