Patient Registration

Your photo ID and insurance card are required at the time of your visit.

SOONER URGENT CARE

Reason for Visit: _____ **How did you find us?** Facebook Bus-stop Google

Patient Information

Last Name: _____ First Name: _____ MI: _____
DOB:_____/_____/_____ SEX:_____ SSN:_____ - _____ - _____
Address:_____City:_____State/Zip:_____
Cell:_____Home Phone:_____Email:_____
Ethnicity: Hispanic/Latino? Y or N Race:_____
Marital Status *(Please circle one)* Single Married Divorced Legally Separated Widowed

Allergies:_____ **Last Menstrual Period:**_____
Pharmacy:_____**Address**:_____**Phone:**_____

Emergency Contact

Name:_____Phone:_____Relationship:_____

Responsible Party/Parent or Guardian (COLLEGE STUDENTS **MUST** PROVIDE ALTERNATE ADDRESS TO SEND BILLS)

Name:_____Relationship to Patient:_____
DOB:____/_____/_____ SSN:_____ - _____ - _____ Phone:_____
Address:_____ City:_____State/Zip:_____

Insurance Information (a copy of the card(s) will need to be provided to be scanned)

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
ID #: **GROUP #:**	**ID#:** **GROUP #:**
POLICY HOLDER NAME:	**POLICY HOLDER NAME:**
SSN: DOB:	SSN: DOB:
EMPLOYER:	EMPLOYER:
PATIENT RELATIONSHIP TO INSURED:	PATIENT RELATIONSHIP TO INSURED:

Email: sooneruc@gmail.com

Employment Status *(Select one)* OEmployed OUnemployed OFull Time Student OPart Time Student ORetired
Business Name:_____Phone:_____
Is this an on the job accident? Y or N Date of injury:_____Is this a motor vehicle accident? Y or N

Primary Care Physician:_____ Phone:_____
Address:_____City:_____State/Zip:_____

I agree and consent to releasing information to me in the following manner: *(Please initial)*
Via Home Telephone Ok to leave detailed message _____
Via Mail Ok to mail to home address _____
Via Email Ok to send results and leave detailed message _____

Any restrictions on the type of information? _____

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_____ Please initial if you will accept **text messaging** from the Sooner Urgent Care. By initialing you acknowledge and understand that standard messaging and data rates may apply and that Sooner Urgent Care is not responsible for any costs associated with your cell phone carrier.

Consent to Treatment (☐ if signing for minor/minors name:_____)

Authorization to release or use information for treatment, payment, or health operations
I hereby authorize the release or use of my individually identifiable health information (Protected health information or PHI) and medical information buy Sooner Urgent Care in order to carry out treatment, payment or health care operations. You should review our Notice of Policy Practices for a more complete description of the potential release and use of such information. You have the right to review such Notice prior to signing this consent form - it is available from our front desk staff. We reserve the right to change the terms of the Notice of Privacy Practices at anytime. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.
You retain the right to request that we further restrict how your PHI is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to requested restriction(s), such restrictions are than binding on the Practice.

Authorization to release information to a family member / friend.
As required by the Health Insurance Portability and Accountability Act of 1996 you have the right to nominate one or more persons to act on your behalf with respect to your PHI. By completing this form, you are informing us of your wish to designate the named person as a personal representative with respect to uses and disclosures of your PHI.

I,_____ (printed name/DOB), hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of PHI.

_____(*Printed Name of Personal Representative*)
The authority of this person, when acting as my personal representative, is restricted to the following functions:
This person is to be afforded all of the Privileges that would be afforded to me with respect to my Protective Health Information. I acknowledge and understand that I may revoke this designation at anytime by signing and the revocation section of my copy of this form and returning it to Sooner Urgent Care 2100 W Lindsey St. Suite B, Norman, OK 73069. I further acknowledge and understand that any relocation does not apply to the extent that persons authorized to use or disclose my Protected Health Information have already acted in reliance on this designation.

By signing below, I consent to be treated at Sooner Urgent Care. I attest that the information given is accurate to the best of my knowledge. I have been given access to a copy of the Notice of Privacy Practices, Financial Responsibilities and Ownership Disclosure. I understand and agree to the terms.

Signature of Patient/Guardian:_____Date:_____

Assignment of Insurance Benefits: I authorize payment directly to SOONER URGENT CARE LLC for all benefits otherwise payable to me.

Guarantee of payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid by or billed to my insurance company or any other third-party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable Insurance co-pays, co-insurance, and deductibles today. If you are unable to verify my insurance at the time of service, I will pay for all services. I am responsible for knowing and understanding the benefits and limitations of my insurance coverage.

By signing below, I attest that the information provided above it true and accurate

Signature of Insured/Guardian:_____Date:_____

SELF-PAY ONLY: *I agree that my insurance will not be billed and I will be seen today as a self-pay patient.*
Signature of Insured/Guardian:_____Date:_____