Patient Registration Form

PATIENT INFORMATION
(This section refers to the patient ONLY)
126 Avocado Ave, Suite 102, Perris, CA 92571
12800 Heacock St, Suite A-4, Moreno Valley, CA 92533
T:951.490.4910 F: 951.490.4920

Last Name:_____**First Name:**_____**MI**:_____

Address:_____**City:**_____**State:**_____**Zip:** _____

DOB: _____

Sex: ☐Male ☐ Female

Contact Numbers (please check preferred #)

☐ **Home:** _____

☐ **Cell:** _____

☐ **Work:** _____

Please provide your email address so that we can let you know about any insurance carrier changes, health alerts, changes in hours, new clinic locations, changes to our services and other important issues. This information will not be provided to a Third Party.

Email:
_____

It is our general policy to follow-up on your care by contacting you within 48 hours of your visit. If you do not wish to be contacted, please check the box: ☐

Primary Care Physician's (PCP) Name:_____**City/State:**

Preferred Pharmacy:_____**City/State:**

EMERGENCY CONTACT

Last Name:_____**First Name:**_____**Phone Number:**

Relationship to the Patient: ☐ Parent ☐ Spouse ☐ Other _____

RESPONSIBLE PARTY
(This section refers to the person/party who should receive the bill)

Relationship to the Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section)

Last Name:_____**First Name:**_____**MI**:_____**SSN:**_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Home phone: (_____)_____**Cell phone:** (_____)_____**Work phone:** (___)_____

INSURANCE INFORMATION
(This section refers to the Insurance Subscriber)

Last Name:_____**First Name:**_____**DOB**:_____**SSN:**

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) _____

Insurance Carrier: _____**Insurance Carrier: ID#**_____

SIGNATURE

I certify that the information provided is correct to the best of my knowledge. I will not hold **RAPID CARE ENTERPRISES INC.,** its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form. I hereby voluntarily consent to treatment for me or my dependent at **RAPID CARE ENTERPRISES INC.,** and authorize such treatments, examinations by its providers.

Print Name:_____Relationship to Patient: _____

Signature:_____Date:_____