

Registration Form

Palm Bay Urgent Care

1155 Malabar Road #10
Palm Bay, Florida 32907

Patient Name _____
(Last) (First) (MI)

Social Security # _____ **DOB** _____ **Age** _____
Sex _____ **Marital Status** _____

Local Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Work** _____ **Cell** _____

Parent/Guardian _____
(If Applicable)

Emergency Contact _____ **Phone** _____

Out of State Address _____

City _____ **State** _____ **Zip** _____

How did you hear about us? _____

Insurance Info

Payment Method _____

Primary Insurance _____ **ID#** _____

Policy Holder _____

DOB _____ **Social Security #** _____

Secondary Insurance _____ **ID#** _____

Policy Holder _____

DOB _____ **Social Security #** _____

I hereby authorize Dr. Bjorn Dimberg to furnish all information concerning my illness and treatment to the insurance company to help secure payment for services rendered. I understand that certain insurance claims may be filed as a courtesy. However, if for any reason the claim is denied, I am responsible for payment. Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance or third party payer within a period of time not to exceed 60 days.

Patient/Guardian Signature _____ **Date** _____

Reason for Visit

Today's Date 4/30/2009

[Empty box for Reason for Visit]

Symptoms

Patient Name

(Last) (First) (MI)

Social Security #

DOB

Age

Sex

Marital Status

Phone

Work

Cell

Primary Care Physician

Past Medical History

MD Notes

Heart Disease 0
Diabetes 0
High Blood Pressure 0
Stroke 0
Cancer 0
Other

[MD Notes section with multiple lines]

Family History

Cancer 0 Heart Disease 0
Stroke 0 Diabetes 0
Other

Past Surgery

Appendix 0 Hysterectomy 0
Gallbladder 0 C-Section 0
Heart Disease 0
Other

List medications you are taking.

[Empty box for List medications]

Allergies (List all or state "none")

[Empty box for Allergies]

Is visit related to auto accident? 0
Is visit related to work injury? 0
Have you ever been a plaintiff or plaintiffs counsel in a lawsuit? 0
Do you plan on filing a lawsuit related to the condition you are here to have evaluated? 0
Do you use tobacco? ##### Do you drink alcohol? 0

Female Patients

Are you pregnant? 0 When was your last menstrual cycle?
Are you breast feeding? 0

Patient/Guardian Signature

Date