MIDLANDS FAMILY URGENT CARE 312 Olson Dr. Ste. 101, Papillion, NE 68046

PATIENT REGISTRATION

Patient Information

Reason for being seen today: _____

Full Name: _____ Age: _____ DOB: _____-_____-_____ Male or Female

Address: _____APT #:_____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Social Security #: _____-____-_____

Race: (Please check one)
___ American Indian/Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or other Pacific Islander
___ White
___ Decline to Specify

Ethnicity (Please check one)
___ Hispanic or Latino
___ Not Hispanic or Latino
___ Decline to Specify

Marital Status (Please check one)
___ Single ___ Partnered
___ Married ___ Widowed
___ Divorced

Primary Care Physician Name: _____ No PCP ___

Parent/Guardian Information/Financially Responsible Party (for patients under 19 years of age)

Full Name: _____Age: _____ DOB: _____-_____-_____ Male/Female

Address: _____ APT #:_____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Social Security #: _____-_____-_____

Relationship to Minor/Patient: Mother ☐ Father ☐ Grandparent ☐ ☐ Other: _____

Preferred Pharmacy Name & Location: _____

Emergency Contact Information:

Full Name: _____ Relationship: _____
Home Phone: (_____) _____-_____Cell Phone: (_____) _____-_____Work Phone: (_____) _____-_____

Primary Insurance Policy Holder Information **All Information is required**

Please be aware that if you do not provide all required information, we will not be able to file properly with your insurance company and you will be responsible for the visit.

Insurance Name: _____

Policy Holder's Full Name: _____ Policy Holder's DOB: _____-_____-_____

Policy Holder's Address: _____ APT #_____ City: _____ State: _____ Zip: _____

Policy Holder's Social Security #: _____-_____-_____ Policy Holder's Phone Number: (_____) _____-_____

Policy Holder's Employer: _____

Relationship to Insured: Self ☐ Spouse ☐ Child ☐ ☐ Other: _____

Secondary Insurance Policy Holder Information – if applicable

Please be aware that if you do not provide all required information, we will not be able to file properly with your insurance company and you will be responsible for the visit.

Insurance Name: _____Policy Holder's Full Name: _____
Policy Holder's DOB: _____-_____-_____ Policy Holder's Address: _____
APT #_____ City: _____ State: _____ Zip: _____ Policy Holder's Social Security #: _____-_____-_____
Policy Holder's Phone Number: (_____) _____-_____
Policy Holder's Employer: _____
Relationship to Insured: Self □ Spouse □ Child □ Other: _____

Midlands Family Urgent Care

How did you hear about us?: (Please check all that apply)

❑Family ❑Friend ❑Co-Worker ❑Phone book/yellow pages ❑Employer ❑Saw building/sign

❑Internet Search ❑Referred by my PCP ❑Flyer/Magnet ❑Prior Visit

❑Newspaper or other publication ❑Other (Please explain)

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