



Washington Urgent Care

Part of the Washington Hospital Healthcare System

2500 Mowry Ave, Suite 212, Fremont, CA 94538-1605 • (510) 608-6174

PLEASE PRINT ALL INFORMATION

Patient's Last Name: _____ First: _____ Middle: _____

Single Married Widowed Date of Birth: _____ Age: _____ Male or Female

If Accident: Date: ___/___/___ How: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip Code: _____

Home Ph #: () _____ Cell Ph #: () _____ Primary Care MD _____

Employer: _____ Work Ph #: () _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

PLEASE LIST A RELATIVE OR FAMILY FRIEND

Emergency Contact: _____ Relationship to Patient: _____

Emergency Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Phone Number: () _____

FINANCIAL RESPONSIBILITY Check one Self Company Parent/Guardian Other _____

(Insured Party) Relationship to Patient: _____ Date of Birth: _____

Last Name: _____ First: _____ Middle: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Employer Name: _____ Work #: () _____

Employer Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ PPO or HMO POS Office Visit Copay \$ _____

ID# _____ Group # _____ Medical Group (If HMO): _____

Secondary Insurance: _____ PPO or HMO POS

ID# _____ Group # _____ Medical Group (If HMO): _____

Secondary Subscribers Name: _____

(Insured Party) Relationship to Patient: _____ Date of Birth: _____

I consent to the treatment and/or procedure(s) necessary for the above named patient. If lab or x-ray is needed, WUC may access my medical records through the Washington Hospital electronic system and I will receive a separate bill for my laboratory services.

I understand that payment of charges incurred is due at the time of service unless financial arrangements have been made prior to treatment. I further authorize and request that insurance payments be made directly to Washington Urgent Care. Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided that may not be covered by your insurance company for the following reasons; ex., not a covered benefit, not referred or authorized, or determined not to be eligible for coverage with Washington Urgent Care and Medical Providers. I am aware that I have the right to appeal the insurance company's determination. If a denial is received, I will be responsible for the amount of this bill.

By signing this Registration form, you consent to the use and disclosure of your protected health information for the purposes of treatment, payment, and healthcare operations, and acknowledge the receipt of the current WUC Notice of Privacy Practices. Also, by signing, you have read and fully understand the above consent of treatment and financial responsibility.

Signature of Patient or Parent/Guardian

Date