FOR OFFICE USE ONLY: TIME IN:______________

☐ ROCKY MOUNT ☐ ROANOKE RAPIDS ☐ WILSON

CAROLINA QUICK CARE PATIENT REGISTRATION

PATIENT LAST NAME: ____________________

PATIENT FIRST NAME: ____________________ MIDDLE INITIAL: ________

SOCIAL SECURITY NUMBER: ____________________ DATE OF BIRTH: ________

HOME PHONE NUMBER: ____________________ CELL PHONE: ________

GENDER: ☐ MALE ☐ FEMALE

STREET ADDRESS: ____________________

CITY: ____________________ STATE: ________ ZIP: ________

REASON FOR TODAY'S VISIT: ____________________

____

E-MAIL ADDRESS : ____________________ PATIENT EMPLOYER: ____________________

PRIMARY CARE PHYSICIAN: ____________________ MARITAL STATUS: ____________________

WHERE DID YOU HEAR ABOUT CAROLINA QUICK CARE?

________ RADIO
________ DOCTOR REFERRAL
________ CLINIC SIGN
________ NEWSPAPER
________ MAILER
________ PHONE BOOK
________ BEEN HERE BEFORE
________ OTHER
________ WORK
________ INSURANCE
________ FLYER
________ FRIEND/RELATIVE
________ INTERNET

INSURANCE GUARANTOR: ____________________

LAST NAME FIRST NAME M.I.

GUARANTOR'S STREET ADDRESS: ____________________

GUARANTOR'S PHONE : ____________________ SOCIAL SECURITY # ____________________

DATE OF BIRTH: ____________ GENDER: ☐ MALE ☐ FEMALE

GUARANTOR'S EMPLOYER: ____________________

RELATIONSHIP TO PATIENT

PARENT ☐ SPOUSE ☐