WellStar Urgent Care
Patient Registration Form

Date: _____ PLEASE LIST YOUR SYMPTOMS: _____

Time: _____ AM / PM Auto Accident ❒ Yes ❒ No Work Related Injury ❒ Yes ❒ No

Other Type of Accident ❒ Yes ❒ No If Yes, Date of Injury: _____ If Yes, Time of Injury: _____ AM / PM

1. Patient Information (Please complete all spaces)

Patient Last Name	First Name	Date of Birth	Age	Patient Gender ❒ M ❒ F
Street Address	City / State	ZIP Code	Social Security Number	
Home Telephone ❒ check box if primary	Work Telephone ❒ check box if primary	Cell Telephone ❒ check box if primary	Email Address	
Needs Interpreter? ❒ Yes ❒ No	Marital Status	Ethnicity Hispanic or Latino? ❒ Yes ❒ No	Race	Preferred Language / Written Language / Religion
Primary Care Physician	Is your PCP a WellStar physician? ❒ Yes ❒ No	Employer Name	Employment Status ❒ Full-time ❒ Unemployed ❒ Disabled ❒ Part-time ❒ Retired ❒ Student	
Employer Address	City / State	ZIP Code	Employer Telephone	
Emergency Contact Last Name	First Name	Emergency Contact Street Address	City / State	ZIP Code
Emergency Contact Relation to Patient	Legal guardian? ❒ Yes ❒ No	Hearing Impaired? ❒ Yes ❒ No	Visually Impaired? ❒ Yes ❒ No	Home Telephone ❒ check if primary / Work Telephone ❒ check if primary / Cell Telephone ❒ check if primary

How did you hear about us?
❒ Other WellStar Urgent Care ❒ Online Search ❒ Doctor's Office ❒ Friend / Family Referral ❒ Newspaper / Print Ad ❒ Driving by / WellStar sign
❒ Pharmacy ❒ Radio ❒ TV ❒ Minute Clinic ❒ www.wellstar.org ❒ Other (please specify): _____

2. Responsible Party / Guarantor ❒ (Check if self and skip this section)

Guarantor Last Name	First Name	Guarantor Street Address	City	State	ZIP Code
Guarantor Relation to Patient	Guarantor Gender ❒ M ❒ F	Social Security Number	Guarantor Date of Birth	Guarantor Home Telephone	
Guarantor Employer	Employment Status ❒ Full-time ❒ Unemployed ❒ Disabled ❒ Part-time ❒ Retired ❒ Student		Employer Telephone		

3. Medical Insurance Policy Holder ❒ (Check if self and skip this section)

Primary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth
Secondary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth

WellStar Urgent Care Patient Registration Form (page 2)

Assignment of Benefits / Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans or other payors for service rendered by WellStar and the medical professionals caring for me during my treatment in this office. For health care services provided by independent medical professionals (such as radiologists who may read my x-ray films), I understand that I will receive separate bills and that I am responsible for paying them. This assignment will remain in effect until revoked by me in writing, I understand that I am responsible for all charges not paid by insurance.

I authorize WellStar Health System to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this facility and authorize such treatments, examinations, educations, anesthesia, surgical, operations and diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered by attending physicians. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by attending physicians.

By providing a telephone number, I expressly consent and authorize WellStar Health System, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message.

I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care follow-up, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

Signature of Patient / Legal Guardian:	Date: