FIRST CARE
MEDICAL CENTERS, LLC.

Account No.:

2013 ADULT REGISTRATION

Thank you for choosing First Care. How did you hear about our clinic? ☐By Friend ☐Phone Book ☐Newspaper ☐Radio ☐Internet ☐TV ☐Sign ☐Brochure

PATIENT INFORMATION

Last	Suffix	First	M.I.
Mailing Address	City	State	Zip Code
Male/Female	Marital Status	Birth Date	
Employer	Social Security No.	Age	

CONFIDENTIAL COMMUNICATION – First Care Medical Centers LLC attempts to contact patients 48-72 hours after a visit to ensure the best medical care possible. These calls may include lab or x-ray result, or general questions about your well-being.

By initialing, I hereby opt out of any routine calls made by First Care's clinical staff. I do not wish to be contacted. I will be responsible for contacting First Care for health questions or to obtain any test results. _____(Patient Initials)

Home Phone No.	Cellular Phone No.
Work Phone No.	Written Communication: (Please circle one) Mail to my home address: YES NO

INSURANCE COVERAGE

Does Patient have : Medicare? Yes ☐ No ☐ Medicaid? Yes ☐ No ☐ Medicaid ID# _____

INSURANCE CO. #1				INSURANCE CO. #2			
Subscriber Name (Last, Suffix, First, M.I.)				Subscriber Name (Last, Suffix, First, M.I.)			
Subscriber DOB	Sex	Marital Status		Subscriber DOB	Sex	Marital Status	
Mailing Address	City	State	Zip Code	Mailing Address	City	State	Zip Code
Social Security No.	Phone no.			Social Security No.	Phone no.		
Employer				Employer			
Insurance Company				Insurance Company			
Insurance Address				Insurance Address			
Insurance Phone no.				Insurance Phone no.			
Policy no.				Policy no.			
Group no.				Group no.			

This Section For Work or Vehicle Injuries Only

Were you injured on the job? Yes No	Date of Injury:
Were you injured in a Major Vehicle Accident? Yes No	Date of Accident:
Workman's Compensation Local Adjuster / Motor Vehicle Insurance Company	MVA Claim #

Emergency Contact: (Last, First, M.I.)	Phone Number	Relationship:

Consent is hereby given to ***FirstCare*** Medical Centers, LLC and the treating physician/nurse practitioner to administer such treatment and to perform such medical and/or surgical procedures which are deemed necessary. I authorize my insurance benefit to be paid direct to ***FirstCare*** Medical Centers, LLC. I understand that I am financially responsible for any unpaid balance, and should I not pay ***FirstCare*** Medical Centers and my account is sent to collection, I understand that I am financially responsible for any collection agency fees. I authorize ***FirstCare*** Medical Centers, LLC to release any information required for my insurance claim. Charges are all tentative until reviewed by an auditor.

Signature of Patient _____ **Date** _____