



OCCUMED WALK-IN & URGENT CARE  
 1910 N. Church Street Greensboro, NC 27405  
 Phone: (336) 574-0707 Fax: (336) 574-0039

**PATIENT REGISTRATION**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(Last) (First) (Middle)

Spouse or Parents Legal Name: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
(If patient is a child, please list parent's employer)

Spouse's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
(If Married)

Permanent Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Sex: (Circle One) Male Female

Marital Status: Married Divorced Single Widow

If your visit will require receiving a prescription, would you like to utilize our in-house pharmacy?  
 Yes No

**TELL US HOW YOU FOUND US:**

- |                   |          |                |
|-------------------|----------|----------------|
| Pink & Blue Pages | Internet | Yellow Page Ad |
| Family/Friends    | Employer | Sign/Drive By  |

What are we seeing you for today? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Your regular pharmacy and location: \_\_\_\_\_

Are you pregnant? Yes No Do you have a pacemaker? Yes No

## Financial Policy

- 1. Patients with in network insurance** are responsible for deductibles, co-pays, non covered services and items considered to be "not medically necessary" by your insurance company. Please pay the above listed as they are rendered. Any remaining balance should be paid within 30 days. If you or your insurance makes an overpayment, reimbursement will be remitted.
- 2. Patient with out of network insurance.** We expect Payment in full at each visit. Your Insurance will be filed to reimburse you.
- 3. Worker's Compensation Patients.** As a worker's comp patient you may be covered by insurance if your injury has been reported at work and verified with your employer. The patient is ultimately responsible for the balance.
- 4. Patients without insurance** We expect payment in full at the time of service.

I have read and agree to the financial policy stated above that applies to me and I agree to the financial arrangements as outlined.

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Patient or responsible party

Date

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Person signing on behalf of patient (print)

Relationship to patient

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Address

Phone