

**URGENT CARE OF CONNECTICUT
PATIENT REGISTRATION FORM**

PATIENT INFORMATION

Last Name		First Name		Middle Initial
Date of Birth	SSN		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Street		Apartment #	Home phone	
City:	State:	Zip		
Cell phone:		Email: <small>(Please leave blank if you do NOT want to receive email from us)</small>		
Primary Care Physician		PCP City/State		
Preferred Language	Race <input type="checkbox"/> American Indian or Alaska Native; <input type="checkbox"/> Asian; <input type="checkbox"/> Black or African American; <input type="checkbox"/> Native Hawaiian or Other Pacific Islander; <input type="checkbox"/> White		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	

EMERGENCY CONTACT

Last Name		First Name		Middle Initial
Relationship to the Patient:		Cell phone:		
<input type="checkbox"/> Please check this box if your home address/phone is the same as the patient and do not fill out the remainder of this section				
Street		Apartment #	Home phone	
City:	State:	Zip		

BEST FORM OF CONTACT

Do you wish to receive a follow-up call about your care? Yes No
Which number is best to reach you? Home Phone Mobile Phone Work Phone

INSURANCE INFORMATION

Is the patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name of Primary Insurance Company:			Plan Name:	
ID Number:		Group #:		
Subscriber Last Name:		First Name		Middle Initial
Date of Birth	SSN		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Street		Apartment #	Home phone	
City:	State:	Zip		
Relationship to patient:				

PERSON RESPONSIBLE FOR BILL:

<input type="checkbox"/> Please check this box if the patient is the person responsible for the bill and do not fill out this section				
<input type="checkbox"/> Please check this box if the emergency contact is the person responsible for the bill and do not fill out this section				
<input type="checkbox"/> Please check this box if the primary carrier of the insurance is the person responsible for the bill and do not fill out this section				
Last Name		First Name		Middle Initial
Date of Birth	SSN		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Street		Apartment #	Preferred phone	
City:	State:	Zip		
Relationship to patient:				

Last Updated: 03/20/2012

Urgent Care of Southbury
Urgent Care of Brookfield
Urgent Care of Norwalk
Urgent Care of Ridgefield

900 Main Street South, Southbury, CT 06488
31 Old Route 7, Brookfield, CT 06804
346 Main Ave., Norwalk, CT 06851
10 South St. Suite 101, Ridgefield, CT 06877

Tel: 203-262-1911
Tel: 203-885-0808
Tel: 203-846-0005
Tel: 203-431-4600

Fax: 203-262-9434
Fax: 203-885-0813
Fax: 203-846-0012
Fax: 203-431-4601

Summary Notice of Privacy Practice

The following is a brief summary of your rights and our responsibilities as detailed in the Notice of Privacy Practices. This summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. **Uses and Disclosures:** We may use the information we develop and collect for treatment by our practice or disclose the information to others whom we refer you to for treatment, payment, and certain health care “operations” such as improving competence and quality. We may disclose your information to transcription or billing services. We may call your home or mobile phone and may leave a message on your answering machine if you have one. We may disclose information to your family about your location, general condition or death. ***If you are available and able, we will ask your consent first.*** We will not disclose your information for marketing purposes without your written permission. Your medical information may be disclosed without your authorization as required by law, for public health purposes.
2. **Other Uses and Disclosures:** Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.
3. **Your Health Information Rights:** You have a number of rights under state and federal law which are subject to the terms and conditions specified in the Notice.
 - a. You may request restrictions on certain uses and disclosures of your information.
 - b. You may request that you receive your information from us in a certain way.
 - c. You may inspect and request a copy of your medical records.
 - d. You may request an amendment to any record you believe is inaccurate.
 - e. You may request an accounting of disclosures made of your records.
 - f. Authorization to release medical records to:
_____ (name)
_____ (relationship to patient)

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient (please print) _____

Signed: _____ Date: _____