UCA Interprofessional Teaching Center

Registration Information

All information contained in this document is strictly confidential and will become part of your medical record.

Patient Information

Name (Last, First, Middle):_____ Maiden: _____

Address:_____ City:_____ State:_____ Zip: _____

DOB:_____ SSN:_____ Phone: (____)_____

Email Address: _____ Occupation: _____ Employer: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____)_____ Primary Care Provider: _____

If the patient is a minor (under the age of 18), please provide information for the parent or legal guardian.

Parent/Legal Guardian Name: _____ Phone: (_____)_____

Primary Insurance Information

Insurance Company: _____ ID #: _____

Plan: _____ Group: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employee: _____ Relationship to Patient: _____

Preferred Pharmacy: _____ Pharmacy Phone: (_____)_____

Secondary Insurance Information

Insurance Company: _____ ID #: _____

Plan: _____ Group: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employee: _____ Relationship to Patient: _____

Preferred Pharmacy: _____ Pharmacy Phone: (_____)_____

Medical History

Reason for Visit: _____

Please List All Current or Past Medical Problems and Approximate Date: _____

_____

_____

Please List All Current Medications, Dosage, and Duration: _____

_____

_____

Please List Any Allergies to Medications: _____

_____

Authorization

I certify that the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to UCA Interprofessional Teaching Center. I acknowledge that I am responsible for payment if my insurance company denies my claim.

_____ _____

Patient Name – Print Date

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Signature (if patient is a minor) Date