



SAVANNAH URGENT CARE
485 Jimmy DeLoach Parkway, Building B, Unit D
Savannah, GA 31407

PATIENT REGISTRATION INFORMATION

Patient Name: Last _____ First _____ MI _____

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____ Email: _____ @

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____ Other: (____) ____ - ____

Gender: ☐ Male ☐ Female ☐ Other Please Specify: _____

Race: ☐ Black ☐ Hispanic ☐ White ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Please notify the staff of a disability that may require special needs or of a barrier to communication or educational instruction that would prevent the understanding of information about the patient's health status, treatment, or the informed decision making process, such as; foreign language, hearing or speech impairment, difficulty with reading or writing or inability to comprehend verbal instruction. Assistive services within our capability will be provided to you free of charge.

Emergency Contact: _____ Phone: (____) ____ - ____

Relationship: _____

Guarantor / Responsible Party for minor

☐ Check box if address and phone number is the same as the patient's information.

Last Name: _____ First Name: _____ MI: _____

Relationship to patient: _____

Date of Birth: ____ / ____ / ____ Guarantor Social Security #: ____ - ____ - ____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____ Other: (____) ____ - ____

Guarantor Employer: _____ Phone: (____) ____ - ____

Primary Insurance Coverage

Insurance Company: _____ Name of Policy Holder: _____

Relationship to Patient: _____ Insured D.O.B.: ____ / ____ / ____

Insured Social Security #: ____ - ____ - ____

Secondary Insurance Coverage

Insurance Company: _____ Name of Policy Holder: _____

Relationship to Patient: _____ Insured D.O.B.: ____ / ____ / ____

Insured Social Security #: ____ - ____ - ____

I verify that the above information provided is true and correct to the best of my knowledge. I understand that the company will require me to update this information at least annually and as necessary when changes occur in my status.

X_____

Date: ____ / ____ / ____

Signature of Patient / Guardian / Accompanying Adult