HEALTHQUEST Medical Practice

HEALTHQUEST Urgent Care

PLEASE PRINT

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:	First Name:	MI:
Mailing address:		
Street address (if different from above):		
Home Phone: [ ] Preferred	Cell Phone: [ ] Preferred	
Work Phone: [ ] Preferred	Pat Birth Date:	Sex:
PCP: [ ] none	Referring Provider:	
Are you transferring care from another provider? YES NO	Name of Provider:	
Marital Status:	SSN:	
Employer Name:	Address:	
Emergency Contact:	Relationship:	
Emergency Contact Home Phone:	Cell Phone:	Work Phone:
Responsible Party:	Relationship:	

INSURANCE INFORMATION

(Please present your photo ID and insurance card to the receptionist.)

Primary Insurance Carrier:	Effective Date:
Subscriber ID:	Co-pay/Coinsurance amount:
Subscriber:	Subscriber Birthdate:
Relationship to Insured: [ ] Self	Group Number:
Insurance Address:	Insurance Phone:
Secondary Insurance Carrier:	Effective Date:
Subscriber ID:	Co-pay/Coinsurance amount:
Subscriber: [ ] Self	Subscriber Birthdate:
Relationship to Insured:	Group Number:
Insurance Address:	Insurance Phone:

GENERAL INFORMATION

OK to leave messages **at home**: YES NO	OK to leave messages **on cell**: YES NO	OK to leave messages **at work**: YES NO
Ethnicity: [ ] Hispanic [ ] Non-Hispanic [ ] Unknown [ ] Decline	Primary Language: [ ] English [ ] Spanish Other (specify):	
Race: [ ] American Indian/Alaska Native [ ] Asian [ ] Black/African American [ ] White/Caucasian [ ] Hispanic [ ] Other Pacific Islander [ ] Other Race [ ] Decline		
Consent to report immunizations to NYSIIS (New York State Immunization Information System): **SEE NYS CONSENT FORM**		
Pharmacy:	City:	Phone:
Pharmacy:	City:	Phone:
How did you hear about our offices: [ ] Brochure [ ] Internet [ ] Newspaper [ ] Phonebook [ ] Radio [ ] Physician: Name [ ] Family Member: Name		

ACKNOWLEDGEMENT/AUTHORIZATION	INITIAL
I give consent to the physician to provide and perform such medical and/or surgical care, test, procedure, prescriptions, and other services and supplies that are deemed necessary or beneficial by my physician for my health and well being	
The above information is true to the best of my knowledge.	
I authorize Health Quest Medical Practice/Health Quest Immediate Care Center to release medical information required to process my claims.	
I authorize my insurance benefits (Medicare, Medicaid, Commercial, etc…) be paid directly to the physician.	
A copy of our Notice of Privacy Practices has been made available to me.	

Patient/Guardian **Signature**:	**Date**: