TOTALCARE™
EMERGENCY ROOM

Patient Label

How did you hear about us? Drove by | Internet Search | Family/Friend | Doctor's Office | Text Message | Pharmacy | LED Sign

PATIENT REGISTRATION

Last Name:	First:	Middle:	Date of Birth:	Sex: (circle one) Male Female
Address:		Social Security: - -	Email:	
City/State/Zip:		Phone Number:	Ethnicity: (circle one) Non-Hispanic Hispanic / Latino	
Are you having any of these symptoms? Yes | No Trouble Speaking / Breathing Yes | No Vision Change / Loss Yes | No Problems Moving Legs / Arms Yes | No		Race: (Circle all that apply) White | Black | Asian Decent Native American Hispanic / Latino | Pacific Islander Declined to Answer | Other	Marital Status: (circle one) Single | Married | Divorced | Widowed Employer:	
Employer Phone:	Occupation:	Primary Care Physician (PCP):	Primary Care Physician Phone:	
Emergency Contact Name:	Relationship to Patient:	Phone Number: ( )	Preferred Method of Contact: Phone | Work | E-mail | Other:	

Have you been to this facility before? **Yes | No**
Is your insurance the same? **Yes | No**
Is your address the same? **Yes | No**

Please indicate a person(s) with whom we may discuss your health/account.

Name: **Phone #:**

Name: **Phone #:**

INSURANCE INFORMATION

Is this visit due to a work or auto accident? (circle one) Yes | No If yes, continue to accident related section.

Do you or another family member have Medicare, Medicaid or Tricare? (circle one) Yes | No

If you are the primary insured for your policy, a front and back copy of your insurance identification card replaces your need to complete this section. If you are NOT the primary insured for your policy, please provide the information below:

Subscriber's Last Name:	First:	Subscriber's Social Security: - -	Subscriber's Birth Date: / /
Member ID Number:		Group Number:	Patient's relationship to subscriber: (circle one) Self | Spouse | Child | Other:

If you have a secondary policy or any additional health coverage that may cover your emergency room visit today, please complete below:

Subscriber's Last Name:	First:	Subscriber's Social Security: - -	Subscriber's Birth Date: / /
Member ID Number:		Group Number:	Patient's relationship to subscriber: (circle one) Self | Spouse | Child | Other:

ACCIDENT RELATED

Date of Accident:	Type of Accident: (circle one) Work | Auto	If auto, involvement in accident: (circle one) Driver | Passenger | Pedestrian | Cyclist	
Name of Insurance Company:			Phone Number:
Company Address:		City/State/Zip:	Fax Number:
Name of Insured:			Adjuster Name:
Policy Number:		Reported: (circle one) Yes | No	Claim Number: