NOT A PART OF THE MEDICAL RECORD INSURED PATIENTS

1. Please make sure all forms are signed by employee and patient.
2. Please make sure each page in the chart has a patient sticker.
3. Use this checklist to put all forms in order and upload entire chart to the patient's medical archive.

_____Print Presidio Facesheet UC ☐ ED ☐

_____Demographic form complete

_____Copy of ID & Insurance Card

_____Verification of Insurance Coverage/ Benefits

☐ Presidio ☐ Availity ☐ UHC ☐ Call/Fax ☐ Other

_____Quick Reg /Initial form

_____Consent Form/ Assignment of Benefits/Financial Responsibility- Facility and Physicians

____Attach all diagnostic results – Lab & Radiology

_____Patient Registered in EMR

_____Patient Added to Daily Receipts Log

_____Patient Added to Call Back / Follow up Log

____Co-pay Collected $_____ Other:_____

_____ _____

Scanner's Name Date

PATIENT LABEL

WELCOME TO iCARE EMERGENCY ROOM!!!

TO ASSIST US IN THE TRIAGE PROCESS, PLEASE COMPLETE THIS FORM. PLEASE BE PREPARED TO PRESENT IDENTIFICATION.

TIME OF ARRIVAL_____DOB_____PHONE_____

Note to registration: Time must match the time on the registration computer!!

WHAT IS YOUR EMERGENCY? IS YOUR CONDITION DUE TO:

__MOTOR VEHICLE ACCIDENT? __ON THE JOB?

PLEASE PRINT ALL ANSWERS
NAME:
HAS THE PATIENT BEEN SEEN HERE BEFORE YES NO
REASON FOR TODAY'S VISIT?
ARE YOU HAVING CHEST PAIN? YES NO
ARE YOU HAVING TROUBLE BREATHING OR HAVE SHORTNESS OF BREATH? YES NO
ARE YOU HAVING TROUBLE SPEAKING, SEEING OR HAVE ANY PROBLEMS MOVING LEGS OR ARMS? YES NO
ARE YOU IN ACTIVE LABOR? YES NO

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one): S / M / D / Separated / W
Social Security No.: - -	Phone Number: ( )	Birth Date: / /	Sex: ❑ M ❑ F		
Street Address:	City/State/Zip:	E-mail Address: (this may be used for facility contact)			
Employer:	Employer Phone: ( )	Occupation:			
Primary Care Physician (PCP):	Phone Number: ( )	Preferred method of contact: ❑ Phone ❑ Work ❑ E-mail ❑ Other:			
Primary or Preferred Language:					
Does the patient require any special accommodations? ❑ Yes ❑No If yes, please list:					
How did you Hear about us? ❑ Drove by ❑ Friend/Family Member ❑ Insurance ❑ Internet ❑ Marketing Team ❑Dr's Office ❑ School ❑ Other					

INSURANCE INFORMATION

We accept all commercial insurance policies.

Is this visit due to a work or auto accident? ❑ Yes ❑ No If yes, continue to accident related section.

Please indicate primary insurance: ❑ Aetna ❑ Blue Cross Blue Shield ❑ Cigna ❑ Great West ❑ Humana ❑ Tricare ❑ United Healthcare ❑ Other:

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

If applicable, indicate secondary insurance: ❑ Aetna ❑ Blue Cross Blue Shield ❑ Cigna ❑ Great West ❑ Humana ❑ Tricare ❑ United Healthcare ❑ Other:

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

Accident Related?

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

IN CASE OF EMERGENCY

Name of local Relative/Friend (not living at same address):	Relationship to Patient:	Home Phone: ( )	Leave Message? ❑ Yes ❑ No

By signing this form, I affirm that all information listed herein is true and correct to the best of my knowledge.

Patient Signature