Eisenhower Urgent Care

This demographic information is collected to register patients to be seen in our Urgent Care Clinics, and for the purpose of helping Eisenhower Medical Center and the State of California better serve our patients. All information is kept confidential.

Patient Information:

Sex: ☐ M ☐ F **Marital Status:** ☐ S ☐ M ☐ W ☐ D ☐ SEP ☐ SIGNIFICANT OTHER

Name: _____
Last First Middle

Date of Birth: _____ **Home Phone** ( ) _____ - _____

Cell Phone ( ) _____ - _____

Physical Address: _____
Number/Street

_____
City State Zip

Mailing Address: _____
Number/Street

_____
City State Zip

Emergency Contact Name: _____

Contact Phone : ( ) _____ - _____ **Relationship:** _____

Insurance Information:

Insurance Name _____ **Policy Holder** ☐ **Self** ☐ **Spouse** ☐ **Parent**

Subscriber Name _____ **Date of Birth** _____

Employment Information:

Occupation (or former position): _____

Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐ Active Military Duty ☐ Student

Employer's Name: _____

Employer's Address: _____
Number/Street

_____
City State Zip

Work Contact Phone :( ) _____ - _____

Demographic Information

Race: ☐ American Indian ☐ Asian ☐ Black/ African American ☐ White ☐ Other Race

Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Primary Language: ☐ English ☐ Español ☐ Other (please specify): _____

How did you hear about us?

☐ Sign ☐ TV ☐ Radio ☐ Friend ☐ Employer ☐ Internet ☐ Advertising ☐ Private MD
☐ EMC Hospital ☐ Hotel ☐ Mail ☐ Other