

Registration Form

Atlantis Urgent Care

2194 Hwy A1A Unit 106
Indian Harbour Beach, FL 32937

Patient Name _____ (Last) (First) (MI)	Primary Insurance Company _____ ID# _____
Social Security # _____	Policy Holder's Name _____
DOB _____ Age _____	Policy Holder's SSN _____
Marital Status _____	Policy Holder's DOB _____
Sex _____	Secondary Insurance Company _____ ID# _____
Address _____	Policy Holder's Name _____
City _____ State _____ Zip _____	Policy Holder's SSN _____
Phone _____ Cell _____	Policy Holder's DOB _____
Race/Ethnicity _____	
Primary Language _____	

Parent/Guardian 1. _____ **Parent/Guardian** 2. _____
(If Applicable) (If Applicable)

Who else may we contact regarding your medical record? _____

Reason for visit _____

Is this visit related to an auto accident? _____

Is this visit related to a work injury? _____

Do you plan to file a lawsuit related to the condition you are here to have evaluated? _____

If you are a female patient, are you pregnant? _____

Pharmacy Name _____ **Pharmacy Address** _____

Phone Number _____

I hereby authorize Dr. Bjorn Dimberg to furnish all information concerning my illness and treatment to the insurance company to help secure payment for services rendered. I understand that certain insurance claims may be filed as a courtesy. However, if for any reason the claim is denied, I am responsible for payment. Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance or third party payer within a period of time not to exceed 60 days.

Parent Guardian Signature _____ **Date** _____