LUMIN CARE
FAMILY CARE – URGENT CARE

Patient Registration

All **BOLDED** areas MUST be completed.

LastName: _____ FirstName: _____ MI: _____ Date of Birth: _____/_____/_____

Maiden Name: _____Marital Status: _____ Sex: _____Social Security #: _____-____-_____

Physical Address: _____ City/State/Zip: _____

Mailing Address: _____City/State/Zip: _____

Mobile Phone: _____ Work Phone: _____ Home Phone: _____

Patient Email: _____@_____ Employer Name: _____

Employer Address: _____City/State/Zip: _____

Preferred Pharmacy Name: _____ Pharmacy Phone Number: _____

How Did You Hear About Us? _____

Consents and Contacts: Please indicate a person(s) with whom we may discuss your health/account **(HIPAA).** If the patient is a minor, these people will be authorized to bring him/her in for any medical treatment deemed necessary. **NOTE: If the patient is a minor, parent(s)/guardian must be listed.**

Name: _____ Relationship to Patient: _____

Mobile Phone: _____ Work Phone: _____ Home Phone: _____

Name: _____ Relationship to Patient: _____

Mobile Phone: _____ Work Phone: _____ Home Phone: _____

Name: _____ Relationship to Patient: _____

Mobile Phone: _____ Work Phone: _____ Home Phone: _____

If you would like LuminCare to file with your Insurance these fields MUST be completed.

Primary Insurance Company: _____ Policy ID #: _____ Group #: _____

Policy Holder Name: _____Policy Holder Date of Birth: _____/_____/_____

Relationship to Patient: _____ Policy Holder Mobile Phone: _____

Work Phone: _____ Home Phone: _____

Secondary Insurance Company: _____ Policy ID #: _____ Group #: _____

Policy Holder Name: _____Policy Holder Date of Birth: _____/_____/_____

Relationship to Patient: _____