Patient Registration

Where did you hear about Effingham Express Care?

_____ Friend/Relative _____ Letter/Mailer _____ Dr. Referral _____Website

_____ Phone Book _____ Radio _____ Insurance Directory _____Signage

_____ Existing Patient _____ Facebook _____ Newspaper _____Work

Patient Last Name _____

Patient First Name _____ Middle Initial _____

Social Security Number _____ Date of Birth _____

Gender: ☑ Male ☐ Female

Email: _____
(for billing statements)

Street Address _____

City _____ State _____ Zip _____

Home Telephone _____ Mobile Telephone _____

Marital Status _____

Patient Employer _____

Primary Care Physician _____

Insurance Co-pay amount $ _____

Insurance Card Holder / Guarantor: _____
Last Name First Name M.I.

Guarantor's Street Address _____

Guarantor's City _____State _____Zip _____

Guarantor's Phone # _____

Guarantor's Social Security Number _____ Date of Birth _____

Gender: ☑ Male ☐ Female Relationship to Patient: ☑ Parent ☐ Spouse

Guarantor's Employer Address _____

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