



**PATIENT REGISTRATION
CONSENT FOR MEDICAL TREATMENT**

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Please complete entire form and sign in order to expedite your registration process:

PATIENT INFORMATION			
(last)	(first)	(middle init)	SSN
Name			
Birth Date / /	Male ___ Female ___	Marital Status	
Mailing Address	City	St	Zip
Home Phone	Cell Phone	(optional) Email	
Prim Care Physician	How did you hear about Tyler Urgent Care?		
Emergency Contact Name	Relation	Phone	
PATIENT EMPLOYER INFORMATION (IF OVER 18)			
Employer Name	Phone		
Address	City	St	Zip
PATIENT INSURANCE INFORMATION (Insurance Holder If Different from Patient)			
(last)	(first)	(middle init)	Card Holder SSN
Name			
Employer Name	Card Holder Birth Date / /		
Employer Phone	Relation to Patient		
Address	City	St	Zip

If patient is minor please provide the following information:

PARENT/GUARANTOR INFORMATION			
Parent/Guardian (last)	(first)	(mid init)	Relation
Name			
(if diff from pt)	City	St	Zip
Address	Home Phone	Cell Phone	DOB SSN

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I voluntarily present for treatment and consent to my physician and whomever they may designate as their assistant, associate, training physician and patient care staff to provide my care. Such care may include, but not be limited to, diagnostic procedures, psychotherapeutic treatment, other treatments and medications, pathologic and radiological evaluations and procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations at Tyler Urgent Care.

Patient Signature /or Guarantor if Patient is Minor

Date