

**Wakulla Urgent Care & Diagnostic Center**  
**2615 Crawfordville Hwy, #103, Crawfordville, FL 32327**  
**David Keen, M.D.**

**REGISTRATION FORM**

(Please Print)

Today's Date:		Your Regular Doctor:					
<b>PATIENT INFORMATION</b>							
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is legal name?		(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address			Social Security #:		Home phone #: ( )		
P.O. Box		City:		State:	Zip Code:		
Occupation:			Employer:		Employer phone #: ( )		
Choose clinic because/referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
E-mail Address:							

<b>INSURANCE INFORMATION</b>						
(Please give your insurance cards and picture ID to the receptionist.)						
Person responsible for bill:		Birth date:	Address (if different):		Home phone #: ( )	
Is this person responsible for the bill a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:			Employer phone #: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> CHP	<input type="checkbox"/> Vista	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Aetna	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Workers Comp:		<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. No:		Birth date:	Group no:	Policy no: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):			Subscriber's name:		Group no:	Policy no:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

<b>IN CASE OF EMERGENCY</b>				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no: ( )	Work phone no: ( )
I certify the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Wakulla Urgent Care & Diagnostic Center (Dr. David A. Keen and associates). I understand that I am financially responsible for all charges whether they are paid by my insurance or not. I also authorize the practice or the insurance companies to release any information, including health care data, required to process my claims.				
Patient/Guardian signature			Date	

**Wakulla Urgent Care & Diagnostic Center**  
2615 Crawfordville Hwy, #103, Crawfordville, FL 32327  
David Keen, M.D.

Date: \_\_\_\_\_

PATIENT CONSENT FORM

I hereby grant Wakulla Urgent Care permission to treat myself for any illness or injury I may encounter.

I understand that my medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without written consent.

If insurance is to be filed, I grant permission for medical information to be released to the insurance company if required for processing a claim, and hereby assign benefits to Wakulla Urgent Care.

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Please list two names and phone numbers to call in case of an emergency:

---

---

---

PARENT/GUARDIAN CONSENT FORM

In the event of my absence or availability, I hereby grant Wakulla Urgent Care permission to treat my child/ward \_\_\_\_\_ for any illness or injury he/she may encounter.

I understand that all medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without my written consent.

If insurance is to be filed, I grant permission for medical information to be released to the insurance company if required for processing a claim; and hereby assign benefits to Wakulla Urgent Care.

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Please list two names and phone numbers to call in case of an emergency:

---

---

**Wakulla Urgent Care & Diagnostic Center**  
2615 Crawfordville Hwy, #103, Crawfordville, FL 32327  
David Keen, M.D.

**HIPAA Authorization for Release of Information**  
**Wakulla Urgent Care & Diagnostic Center**

I hereby authorize use or disclosure of protected health information about myself

**(PATIENT NAME)** \_\_\_\_\_ **(DOB)** \_\_\_\_\_

as described below.

The following people may receive any and all protected health information about myself.

Name	Date of Birth	Phone Number	Relationship

I may revoke or withdraw this authorization by notifying **Wakulla Urgent Care & Diagnostic Center** in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on \_\_\_\_\_.

***THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.***

\_\_\_\_\_  
Signature of patient or authorized representative Date

\_\_\_\_\_  
Signature of Witness or Office Staff Date