PREMIER MEDICAL ASSOCIATES

Building Better Care

PATIENT REGISTRATION

Welcome to our office. Please provide us with the following information. If you have any questions or concerns, please contact a staff member. Thank you kindly. PLEASE PRINT.

Last Name _____ First Name _____ MI _____

SS# _____-____-_____ Date of Birth ____/____/_____ Sex Male Female

Address _____ Apt/Suite _____

Zip Code _____ City _____ State ____

Main Contact Phone Number (_____)_____-_____ Is this the Home Cell Work

Other Contact Phone Number (_____)_____-_____ Is this the Home Cell Work

If a parent or guardian, please indicate relationship _____

Other Contact Phone Number (_____)_____-_____ Is this the Home Cell Work

If a parent or guardian, please indicate relationship _____

Employer _____

Address _____ Apt/Suite _____

Zip Code _____ City _____ State ____

Email Address _____

Marital Status Single Married Divorced Widowed Seperated

Employment Status Full Time Part Time Not Employed Self Employed Retired Military Duty

Student Status Full Time Part Time Not A Student

The following information is mandated by the Federal government as part of healthcare reform. Please note that this information is not used by Premier Medical Associates in any way.

Race Asian Native Hawaiian or Pacific Islander Hispanic Black or African American White Declined

Ethnicity Hispanic or Latino Non-Hispanic or Latino Declined

Preferred Language English Other _____

This section designates who will be responsible for payment of the account. Unless a minor or an adult with a special circumstance, the patient is the responsible party. This section does not reflect the subscriber of any insurance policies.

Person Responsible for the Account is Patient Parent/Guardian Other _____
(if the patient is not financially responsible, please complete the following)

Last Name _____ First Name _____ MI _____

SS# _____-____-_____ Date of Birth ____/____/_____ Sex Male Female

Address _____ Apt/Suite _____

Zip Code _____ City _____ State ____

Main Contact Phone Number (_____)_____-_____ Is this the Home Cell Work

Emergency Contact Information

Last Name _____ First Name _____ MI _____

Main Contact Phone Number (_____)_____-_____ Is this the Home Cell Work

Other Contact Phone Number (_____)_____-_____ Is this the Home Cell Work

Relationship Spouse Parent/Guardian Child Sibling Other _____

PRIMARY HEALTH INSURANCE INFORMATION

Insurance Name _____

Address _____ Apt/Suite _____

Zip Code _____ City _____ State ____

Policy ID _____ Group #_____

Subscriber Relationship to Patient Same Spouse Parent/Guardian Other _____
If the patient is not the subscriber, please provide the following

Subscriber Last Name _____ First Name _____ MI _____

Date of Birth ____/____/_____ Employer _____

SECONDARY HEALTH INSURANCE INFORMATION

Insurance Name _____

Address _____ Apt/Suite _____

Zip Code _____ City _____ State ____

Policy ID _____ Group #_____

Subscriber Relationship to Patient Same Spouse Parent/Guardian Other _____
If the patient is not the subscriber, please provide the following

Subscriber Last Name _____ First Name _____ MI _____

Date of Birth ____/____/_____ Employer _____

If this visit is the result of an accident, please provide the following information

Was this injury Auto-related Work-related Other _____

Insurance Name _____

Address _____ Apt/Suite _____

Zip Code _____ City _____ State ____

Claim # _____ Date of Accident ____/____/_____

Contact/Agent Last Name _____ First Name _____ MI _____

Phone Number (_____)_____-_____

For Medicare Patients
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Premier Medical Associates for any services rendered to me by them. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____/_____/_____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Premier Medical Associates for any services furnished to me by them. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits payable for related services.

Signature _____ Date _____/_____/_____

For All Other Patients
I authorize release of any medical or other information necessary to process claims as well as payment of medical benefits to Premier Medical Associates.

Signature _____ Date _____/_____/_____

HIPAA Notice of Privacy Practices
I acknowledge that I have been given a copy of this office's Notice of Privacy Practices, which describes how my health information is used and shared.

Signature _____ Date _____/_____/_____

If signatures are those of a representative of the patient, please provide the following:

Name _____

Relationship _____