Premier Health
Premier Physician Network

Work-Related/Auto/Other Injury:
Use Supplement Info Form

Minor Registration Form

PATIENT INFORMATION:

*Patient Name: _____ *SSN: _____
Last First Full Middle 123-45-6789

*Sex ○ Male Data of Birth: ____/____/____ Aliases/Nicknames: _____
○ Female

*Street Address/PO Box: _____ *City, State Zip: _____

County: _____ Home Phone: (____) _____ Email Address: _____

Who Does Child Live With?: _____ Relationship to Child: _____

Name of Legal Guardian, if different _____ Legal Guardian Phone _____

Language _____ Ethnic Group _____ Patient Race _____

Special Needs: Hearing _____ Language _____ Speech _____ Vision _____ Other _____

EMERGENCY CONTACT:

Mother/Legal Guardian Name _____

Home Phone (___) _____ Work Phone (____) _____ Cell phone (___) _____

Father/Legal Guardian Name _____

Home Phone (____) _____ Work Phone (____) _____ Cell phone (____) _____

Name: _____ Phone: (____) _____ Alternate Phone: (____) _____ Relation to Patient: _____

RESPONSIBLE PARTY (GUARANTOR): Check if Same as Patient !

*Relation to Patient: ☐ Self ☐ Parent ☐ Other ☐ Spouse ☐ Child

*Name: _____ *SSN: _____
Last First Full Middle 123-45-6789

*Street Address/PO Box: _____ *City, State Zip: _____

○ Male
*Sex ○ Female *Data of Birth: ____/____/____ *Home Phone: (____) _____ Work Phone: (____) _____

*Employer _____ *Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Self Employed ☐ Unemployed ☐ Active Military

Employer Street Address: _____ City _____ Zip _____

INSURANCE/POLICY HOLDER INFORMATION (SUBSCRIBER): Please present Insurance cards to receptionist

*Primary Insurance _____ *Effective Date____/____/____

*Policy Holder Name _____ *SSN _____
123-45-6789

*Member ID _____ *Group Number _____ *Policy Holder Birthdate ____/____/____

*Sex ○ Male ○ Female

*Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

*Patient Relation Subscriber: ☐ Self ☐ Spouse ☐ Parent to Child ☐ Other

*Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Self Employed ☐ Unemployed ☐ Active Military Employer _____ Employer Phone (____) _____

Please complete the reverse side.

*Required Fields

SECONDARY INSURANCE:

Secondary Insurance _____ Effective Date ____/____/____

Policy Holder Name _____ *SSN: _____
123-45-6789

*Member ID _____ *Group Number _____ *Policy Holder Birthdate ____/____/____

*Sex ○ Male ○ Female

*Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

*Patient Relation Subscriber: ☐ Self ☐ Spouse ☐ Parent to ☐ Child ☐ Other

*Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Self Employed ☐ Unemployed ☐ Active Military

Employer _____ Employer Phone (____) _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

□ CareFinders ☐ Friends / Family ☐ Physician ☐ Advertisement ☐ Other _____

Whom may we thank for your referral to this office? _____
Name Address (if know) Phone #

CONSENT TO TREATMENT AND AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I consent to and authorize the physicians and staff of Premier Physician Network (PPN) to provide all necessary care, including examinations, testing and treatment. I understand that certain care may be provided by telehealth technology. Such care involves a health care provider who is at a remote location at the time of the service. Telehealth often involves the transmission of video, audio, images, and other types of data that is encrypted for privacy. The remote provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription for myself or my child.

I consent to PPN using and disclosing my protected health information to carry out treatment, payment, or health care operations.

Premier Health and PPN may use any information provided on this form to communicate with me.

I have been provided with a Notice of Privacy Practices which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that PPN reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager. I have the right to revoke this consent by notifying PPN in writing, except to the extent that PPN has taken action in reliance on my consent.

I hereby authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to PPN any information regarding my Medicare claims under title XVII and XIX of the Social Security Act. I further authorize any holder of my medical information to release any information needed to determine benefits payable by my insurance program/company.

FINANCIAL AGREEMENT

I realize that all charges for medical services are my responsibility to pay. I assign and authorize payment be made directly to PPN of all insurance benefits and I agree to pay any balance due. I authorize PPN to contact me by telephone, text message, and/or email at any telephone number or email address associated with my account, which I understand could result in charges to me. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

_____ ____/____/____ ____/____/____
Signature of patient or patient's representative Date Date of Birth

_____ _____
Printed name of patient or patient's representative Relationship to patient or representative's authority to act for the patient.

Siblings seen at this office:

Name	Birthdate
1	____/____/____
2	____/____/____
3	____/____/____
4	____/____/____