Premier Health
Premier Physician Network

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

Registration Form

PATIENT INFORMATION:

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

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

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

County: _____ *Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Email Address: _____ Marital Status: ! Married ! Widowed ! Single ! Divorced

*Occupation: _____ ! Legally Separated ! Significant Other

“Employer: _____ *Employment Status: ! Full Time ! Part Time ! Retired ! Student

*Employer Address: _____ ! Self Employed ! Unemployed ! Active Military

Name of Legal Guardian: _____ Referring Physician: _____

Ethnic Group: _____ Preferred Language: _____ Race: _____ Religion: _____

Special Needs: ! Hearing ! Language ! Speech ! Vision ! Multiple Needs ! No Special Communication Needs ! Other

Primary Care Physician: _____

EMERGENCY PATIENT CONTACTS:

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

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: _____

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

*Employer: _____ *Employment Status: ! Full Time ! Part Time ! Retired ! Student

*Employer Address: _____ ! Self Employed ! Unemployed ! Active Military

*City, State Zip: _____

ADVANCED DIRECTIVES: (circle if applicable)

Do you have an advanced directive? Living Will: ! Y / ! N DNR: ! Y / ! N Durable Power of Attorney for health care: ! Y / ! N

HOW DID YOU HEAR ABOUT OUR OFFICE?

ϒ CareFinders ! Friends / Family ! Physician ! Advertisement Other _____

PLEASE COMPLETE INSURANCE INFORMATION ON THE REVERSE SIDE

*Required Field

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

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

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

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

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

*Employer Address: _____

*City, State Zip: _____

*Primary Insurance: _____ *Effective Date: ____/____/____

*Member ID: _____ *Group Number: _____

*Patient Relation to Subscriber: ϒ Self ! Parent ! Other ϒ Spouse ! Child

* Relationship to Guarantor: ϒ Self ! Parent ! Other ϒ Spouse ! Child

SECONDARY INSURANCE:

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

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

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

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

*Employer Address: _____

*City, State Zip: _____

*Secondary Insurance: _____ *Effective Date: ____/____/____

*Member ID: _____ *Group Number: _____

*Patient Relation to Subscriber: ϒ Self ! Parent ! Other ϒ Spouse ! Child

* Relationship to Guarantor: ϒ Self ! Parent ! Other ϒ Spouse ! Child

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.