

**WELCOME TO PREMIER FAMILY MEDICAL, PC.** Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We are always happy to help.

<b>PERSONAL INFORMATION</b>		Last		First		MI	
PATIENT NAME							
TODAY DATE ____ / ____ / ____ <small>Month Day Year</small>		Social Security # ____ - ____ - ____ (required for all adults)			Birth Date ____ / ____ / ____ <small>Month Day Year</small>		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				Wishes to be called as " _____ "			
Home Phone ____ - ____ - ____		Work Phone ____ - ____ - ____		Cellular ____ - ____ - ____		Pager ____ - ____ - ____	
Address (street) _____ apt / unit # _____				City _____		State _____	Zip _____
E-mail address _____ @ _____			Employer _____		Occupation _____		
Status <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated				Referred by _____			
Where do you prefer to receive calls? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Other: ____ - ____ - ____ <input type="checkbox"/> OK to leave message							
What is the best time to reach you? Time ____ : ____ Days <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THU <input type="checkbox"/> FRI							
In case of an emergency, whom should we contact? Last First MI							
Relationship _____		Work # _____		Home # _____		Cell # _____	
						Pager # _____	

<b>RESPONSIBLE PARTY</b>		Last		First		MI	
NAME OF RESP. PARTY							
Relationship to patient <input type="checkbox"/> Self (if Self, go to "PRIMARY INSURANCE" section) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Employer							
Social Security # ____ - ____ - ____ (required for all adults)				Birth Date ____ / ____ / ____ <small>Month Day Year</small>			
Home Phone ____ - ____ - ____		Work Phone ____ - ____ - ____		Cellular ____ - ____ - ____		Pager ____ - ____ - ____	
Address (street) _____ apt / unit # _____				City _____		State _____	Zip _____
E-mail address _____ @ _____			Employer _____		Occupation _____		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated					

<b>PRIMARY INSURANCE</b>		Last		First		MI	
NAME OF INSURED							
Insured birth date		Relationship to patient			Soc. Sec.#		
Name of insurance company				Insurance Co. address			
Plan type		ID#			Group#		
Insured employer		Date employed			Occupation		
Deductible \$				Amount already used \$			

<b>SECONDARY INSURANCE</b>		Last		First		MI	
NAME OF INSURED							
Insured birth date		Relationship to patient			Soc. Sec. #		
Name of insurance company				Insurance Co. address			
Plan type		ID#			Group#		
Insured employer		Date employed			Occupation		
Deductible \$				Amount already used \$			

Payment is due at time of service unless Premier Family Medical, hence forth known as PFM, has a contract with your insurance carrier. In that case PFM will submit the claim three times. If there is no response after the third submission, the charge will become the responsibility of the patient or his guarantor. If PFM submits a claim for services rendered to the patient identified above, you will obligated to pay PFM for any amounts identified by you carrier as patient responsible, including copayments, deductibles and coinsurance. You are also responsible to pay PFM for any services deemed ineligible or not covered by your insurance plan. PFM will not bill you for contracted fee adjustments. Copayments are due at time of service as well as all other outstanding balances due for the above-mentioned patient and/or any other immediate family member.

**STATEMENT OF PATIENT OR GUARANTOR (please note: MUST BE SIGNED in order to be seen by a health care provider!)**

I have read, understand and accept the above agreement. I authorize and request my insurance company to pay directly to PFM insurance benefits otherwise payable to me. If I receive insurance benefit related to services provided by PFM, I will promptly assign and forward them to PFM. If there is a balance due after my insurance processes the claim, I will pay it in full within 30 days of the monthly billing date. If my balance becomes overdue, a late charge of 1.5% will be assessed each month. I realize that failure to keep this account current may result in PFM being unable to provide additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any further outstanding balances. I also agree to pay \$10.00 administrative processing charge if I neglect to pay my copayment at the time of service and a charge of \$50.00 if I miss my appointment without providing at least 24 hours notice.

**PATIENT OR GUARANTOR SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_ / \_\_\_\_ / \_\_\_\_