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.

PERSONAL INFORMATION

PATIENT NAME (Last / First / MI)

TODAY DATE_____ / _____ / ______ (Month / Day / Year)

Social Security #________- ______ - ________(required for all adults)

Birth Date _____ / _____ / _______ (Month / Day / Year)

Sex ☐ Male ☐ 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 ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated | Referred by

Where do you prefer to receive calls? ☐Home ☐Work ☐Cell ☐Pager ☐Other: _______ - _______ - ________ ☐OK to leave message

What is the best time to reach you? Time _____ : _____ Days ☐MON ☐TUE ☐WED ☐THU ☐FRI

In case of an emergency, whom should we contact? (Last / First / MI)

Relationship | Work # | Home # | Cell # | Pager #

RESPONSIBLE PARTY

NAME OF RESP. PARTY (Last / First / MI)

Relationship to patient ☐ Self (if Self, go to "PRIMARY INSURANCE" section) ☐ Spouse ☐ Parent ☐ Relative ☐ Friend ☐ Employer

Social Security #________- ______ - ________ (required for all adults)

Birth Date ______ / ______ / _________ (Month / Day / Year)

Home Phone_______- _______ - ________

Work Phone_______- _______ - ________

Cellular_______- _______ - ________

Pager _______- _______ - ________

Address (street) | apt / unit # | City | State | Zip

E-mail address @ | Employer | Occupation

Sex ☐ Male ☐ Female | Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

PRIMARY INSURANCE

NAME OF INSURED (Last / First / MI)

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 $

SECONDARY INSURANCE

NAME OF INSURED (Last / First / MI)

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 **P**remier **F**amily **M**edical, **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______ / ______ / _________

OB/GYN CONFIDENTIAL

PATIENT NAME (Last / First / MI)

TODAY DATE ______ / ______ / __________

SSN# _______ _______ __________

Date of birth ______ / ______ / __________

Age

Date of last pelvic exam _____ / _____ / _________

Date of last PAP ______ / ______ / ___________ ☐☐Normal ☐☐Abnormal

Age menses began.

Date of last normal menstrual period? _____ / _____ / _________

Usual number of days between menstrual periods?

If still having Menstrual periods describe them:

Do you ever experience bleeding in-between menstrual periods? ☐Yes ☐ No

How often?

Have you ever had an abnormal PAP Smear? ☐☐Yes ☐☐ No

If yes, when

What treatment was given?

Treatment given by whom?

Age of first intercourse

Frequency of intercourse:

Have you ever: ☐☐been sexually abused ☐☐raped ☐☐pressured into having sex

BREAST HISTORY

Do you perform self-breast exams? ☐☐Yes ☐No

Any Lumps Found. ☐☐Yes ☐☐ No

How often?

Have you ever had an abnormal Mammogram? ☐☐☐Yes ☐☐ No

If yes, when?

What treatment was given? ☐☐Yes ☐☐ No

Treatment given by whom?

CONTRACEPTION

Do you smoke? ☐☐☐☐☐ ☐☐Yes ☐No

How Much?

What type, if any, contraception do you use?

How long have you used this form of birth control?

RISK FOR HIV: Number of partners in lifetime?

Any Sexually Transmitted Disease:

☐☐☐☐☐☐☐☐☐☐☐ ☐Syphilis ☐Gonorrhea ☐HIV

☐☐☐☐☐☐☐☐☐☐☐ ☐Chlamydia ☐Warts ☐Pelvic Inflammatory Disease

HAVE YOU EVER: ☐Had Seizures☐ ☐Wear Contacts

☐ ☐Been hospitalized ☐Had Surgery ☐High Blood Pressure ☐Frequent Headaches

☐ ☐Jaundice ☐Hepatitis ☐Gallbladder disease ☐Diabetes ☐☐Phlebitis

☐Blood Clots ☐Heart Murmur ☐Epilepsy

PREGNANCY HISTORY

Number of Pregnancies?

Live Births?

Miscarriages ☐☐Yes ☐☐ No

Abortions?☐ ☐☐Yes ☐☐ No

DATE OF DELIVERY	TYPE OF DELIVERY	SEX	WEIGHT	LENGTH	COMPLICATIONS

SIGNATURE OF PATIENT ____ DATE______ / ______ / _________