



# REGISTRATION FORM

Physician: \_\_\_\_\_ Office: \_\_\_\_\_

PATIENT INFORMATION						
Last Name		First Name		Middle Initial	Maiden Name	
Address				City/State	Zip	
DOB	Age	Relation to Responsible Party	SS#	Home Phone	Work Phone	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Employer Name & Address		Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed		Cell Phone	
Referring Physician		Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		Patient Student Status <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> Not a Student		
Name of siblings or other family members also coming to this practice:						
How did you hear about us? <input type="checkbox"/> Hospital Help Line <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Provider Directory <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor						
Other: Name: _____    May we thank them? <input type="checkbox"/> Yes <input type="checkbox"/> No						

<input type="checkbox"/> SAME AS PATIENT    RESPONSIBLE PARTY INFORMATION    (If Different from Patient) <i>Person who accompanies child to visit</i>						
Last Name		First Name		Middle Initial	Maiden Name	
Address		S.S.#	Home Phone		Cell Phone	Work Phone
City, State, Zip		Relationship to Patient	Employer Name & Address			
Spouse	Spouse Employer & Address				Spouse Work Phone	

EMERGENCY CONTACT <i>(nearest relative not living with you)</i>		
Emergency Contact Name		Home Phone
Address, City, State & Zip		Work Phone
		Other Phone
		Relation to Patient

PRIMARY INSURANCE INFORMATION				
Insurance Company		Group#/Plan ID	Member Number	Copay Amount
Subscriber Employer Name & Address		Patient Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Subscriber Name & Address		Does your insurance require a referral to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Subscriber DOB	

SECONDARY INSURANCE INFORMATION				
Insurance Company		Group#/Plan ID	Member Number	Copay Amount
Subscriber Employer Name & Address		Patient Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Subscriber Name & Address		Does your insurance require a referral to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Subscriber DOB	

The undersigned patient or guardian certifies that the above facts are correct and agrees as follows:

1. Authority is granted to PriMed Physicians to render needed treatment and/or tests to the above named patient.
2. I authorize PriMed Physicians to release any information required for payment of claims.
3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician, realizing I am responsible to pay noncovered and unauthorized service.
4. I understand that **I am responsible** for charges incurred through PriMed Physicians, not covered by my insurance. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. I have been given PriMed Physician's handout on missed appointments and understand my responsibilities regarding being late or absent.

\_\_\_\_\_  
The above information is correct/patient or Guardian Signature

\_\_\_\_\_  
Date