PriMED PHYSICIANS
Treating You Well.®

PATIENT REGISTRATION FORM

Name:_____ Other Name:_____
First Middle Initial Last Suffix

PATIENT INFORMATION

SS #_____ Birth Date_____ Marital Status: S M D W Sex: M F

Address_____
Street City State Zip

Race: ❑ American Indian/Alaska Native ❑ Black/African American ❑ Caucasian ❑ Hispanic/Latino
❑ Refused/Unknown ❑ Native Hawaiian/Other Pacific Islander ❑ Asian

Ethnicity: ❑ Not Hispanic/Latino ❑ Hispanic/Latino ❑ Unknown/Refused

Language: ❑ English ❑ Spanish ❑ French ❑ Mandarin ❑ Japanese ❑ Hindi ❑ Other

List your contact numbers and ✓ your preferred contact method below:

❑ Home _____ ❑ Cell _____ ❑ Portal Follow My Health

Appointment Reminders and Other Healthcare Communications Preference: ❑ Voice ❑ Text ❑ Email

Employer Name _____ Status: Full-time Part-Time Retired None

Employer Address _____
Street City State Zip

Other household family members who are PriMED patients?

_____ _____
First Last Birth Date First Last Birth Date

_____ _____
First Last Birth Date First Last Birth Date

_____ _____
First Last Birth Date First Last Birth Date

Note: If the patient is a minor, please complete this section regarding financial responsibility.

Guarantor Name _____ Relationship to Guarantor: ❑ Child ❑ Other

Address (if different from patient's)_____
Street City State Zip

ADDITIONAL CONTACT INFO

Name _____ Relationship _____ Phone _____
Please ✓ all that apply: ❑ Emergency Contact ❑ Caregiver ❑ Other Parent

Address _____
Street City State Zip

Name _____ Relationship _____ Phone _____
Please ✓ all that apply: ❑ Emergency Contact ❑ Caregiver ❑ Other Parent

Address _____
Street City State Zip

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INSURANCE INFORMATION

PRIMARY CO _____ Policy/ID # _____ Group # _____

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Parent ❑ Other Subscriber Name (if not the patient) _____

Birth date _____ Employer _____ Employer Phone _____

Employer Address _____
Street City State Zip

SECONDARY CO _____ Policy/ID # _____ Group # _____

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Parent ❑ Other Subscriber Name (if not the patient) _____

Birth date _____ Employer _____ Employer Phone _____

Employer Address _____
Street City State Zip

TERTIARY CO _____ Policy/ID # _____ Group # _____

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Parent ❑ Other Subscriber Name (if not the patient) _____

Birth date _____ Employer _____ Employer Phone _____

Employer Address _____
Street City State Zip

The insurance information I have provided on this form is accurate and complete. If I have omitted any insurance information, then I understand that I will be responsible for payment in full as described in the PriMED Patient Financial Policy.

Patient or responsible party signature: _____ Date: _____

ACKNOWLEDGMENT SIGNATURES

Consent to Email or Text usage for Appointment Reminders and Other Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

I consent to receive text messages from the practice on my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/ feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:

Cell Phone Number: (_____) _____-_____

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/information in the Patient Portal to the following Email Address:
Email Address: _____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details)

Patient or Responsible Party Signature: _____ Name (please print): _____ Date: _____

My signature below acknowledges that I have received the PriMED New-Patient packet, detailing guidelines for accessing care and services provided by PriMED Physicians.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

(Parent/Legal Guardian if patient is under 18 years of age.)