Premier Family Medicine

Patient Registration Form – Please Print Neatly and Complete All Sections

Date: MM / DD /YYYY ________ Provider Being Seen (*circle one*): L. Cecil, MD J. Hudson, MD M. Vejnar, MD K. Benson, FNP E. King, FNP ____________

PATIENT'S INFORMATION

Patient Name: (LAST, Jr,Sr,etc) (FIRST) (MI) (NICKNAME if applicable) Social Security No
- -

Patient's Address (Street and Apt, etc) (CITY) (STATE) (ZIP CODE)

Sex M / F Date of Birth MM / DD /YYYY Phone #s: (HOME) (WORK) (MOBILE) Preferred #?:(*Circle One*) Home Work Mobile

Email Address (*to create Secure Patient "My Chart" Account*): ____________________

MEANINGFUL USE CRITERIA (Required for Government reporting purposes)

Need Interpreter? Yes / No Preferred Language: ____________

Marital Status: __Single __Married __Divorced __Committed Relationship Ethnicity: __Hispanic or Latino __Not Hispanic

Race: __White __ Black __ Asian __ Hispanic __More than 1 Race __Other: ____________

EMPLOYER INFORMATION

Employed: __N/A__Full-time __Part-time Employer: ____________ Phone: ____________

Employer Address: ____________ Profession: ____________

Student: __N/A __Full-time __Part-time Retired: __N/A __Yes Disabled: __N/A __Yes

GENERAL INFORMATION

Emergency Contact: (NAME) (RELATIONSHIP) (WORK PHONE) (HOME/MOBILE PHONE)

Pharmacy Name (*for Electronic Prescriptions*): ____________

Pharmacy Location/Address: ____________ Phone: ____________

PERSON RESPONSIBLE FOR BILL (If Different than above) ☐ Check Here If Same as Above

Name: (LAST, Jr,Sr,etc) (FIRST) (MI) (NICKNAME if applicable) Social Security No
- -

Address (Street and Apt, etc) (CITY) (STATE) (ZIP CODE)

Phone #s: (HOME) (WORK) (MOBILE) Employer Sex M / F Date of Birth MM / DD /YYYY

INSURANCE INFORMATION (Must be information for the Person that the Insurance is Purchased through)

Primary Insurance Company: ____________

ID/Policy Number: ____________

Group Number: ____________

Name of Insured/Cardholder: ____________

Insured's Social Security No: ____________

Sex (circle): M / F Insured Date of Birth: MM / DD /YYYY

Employer of Insured: ____________

Employer Phone Number: ____________

Patient Relationship to Insured: __SELF __CHILD __SPOUSE

Office Copay/Coinsurance/Deductible: ____________

We will not file any Medicaid Policies as Secondary Coverage

Secondary Insurance Company ____________

***If Medicare, we must provide reason*:** ____________

ID/Policy Number: ____________

Group Number: ____________

Name of Insured/Cardholder: ____________

Insured's Social Security No: ____________

Sex (circle): M / F Insured Date of Birth: MM / DD /YYYY

Employer of Insured: ____________

Employer Phone Number: ____________

Patient Relationship to Insured: __SELF __CHILD __SPOUSE