

**PREMIER PRIMARY CARE PHYSICIANS  
ADULT PATIENT REGISTRATION**  
(Ages 18 and over please print)

**Patient Information**

*Please Print - Fill In All Areas*

First Name - MI - Last Name		Nick Name	Birth Date	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Soc. Sec#
Home Address		City		State	Zip
Home Phone Number		Cell Phone Number		E-Mail Address	
Preferred telephone contact is: (circle one) Home / Cell / Business			May we leave a confidential message at this number? Y / N May we e-mail confidential information to this e-mail address? Y / N		

**Patient Employer**

Name of Company	Occupation (Indicate if a Student)	Business Phone Number	
Employer Street Address	City	State	Zip

**Emergency Contact (Friend or Relative)**

Name	Relationship	Phone Number
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Primary Insurance Information	Secondary Insurance Information
Insurance Name: _____	Insurance Name: _____
Policy/ID #: _____	Policy/ID #: _____
Group/Plan #: _____	Group/Plan #: _____
Insurance Effective Date: _____	Insurance Effective Date: _____
Policy Holder Name: _____	Policy Holder Name: _____
Employer: _____	Employer: _____
Policy Holder SSN/DOB: _____	Policy Holder SSN/DOB: _____
Relationship to Patient: _____	Relationship to Patient: _____

How did you hear about us? Internet  Insurance Company  Personal Reference  If so who? \_\_\_\_\_

**Medicare Lifetime Signature on File:** I request that payment of authorized Medicare benefits be made on my behalf to Premier Primary Care Physicians for any services furnished me by the physicians. I authorize any holder of medical information about me to release to CMS and its agents any information to determine these benefits payable for related services.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Private Insurance Authorization for Assignment of Benefits/Information Release:** I, the undersigned, authorize payment of medical benefits to Premier Primary Care Physicians for any services furnished me by the physicians. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Acknowledgement of Privacy Practices:** I have received notice of the Privacy Practices of Premier Primary Care Physicians and I have been provided an opportunity to review these practices.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_