

**Patient Information**

*Please Print - Fill In All Areas*

Child's (Legal) Name: First Name - MI - Last Name		Nick Name	Birth Date	Sex M F	Soc. Sec#
Home Address			City	State	Zip
Home Phone Number (Child)	Cell Phone Number (Child)	May we leave a confidential message at this number? Y / N			

**Mother** (circle one) Birth / Stepmother / Adoptive mother / Foster *Any custody concerns?* Y / N *Legal guardian?* Y / N

Mother's Full Name (First M. Last)		Social Security #	Date of Birth		
Home Address		City	State	Zip	
Mother's Employer Name & Address			Home Phone Number/Cell Phone Number		
			Business Phone Number		
Preferred telephone contact is: (circle one) Home / Cell / Business			May we leave a confidential message at this number? Y / N		

**Father** (circle one) Birth / Stepfather / Adoptive father / Foster *Any custody concerns?* Y / N *Legal guardian?* Y / N

Father's Full Name (First M. Last)		Social Security #	Date of Birth		
Home Address		City	State	Zip	
Father's Employer Name & Address			Home Phone Number/Cell Phone Number		
			Business Phone Number		
Preferred telephone contact is: (circle one) Home / Cell / Business			May we leave a confidential message at this number? Y / N		

**Emergency Contact (Friend or Relative)**

Name	Relationship	Phone Number
------	--------------	--------------

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: _____

**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 financiall

Signature of Patient/Guardian/Guarantor \_\_\_\_\_ Date \_\_\_\_\_

**Acknowledgement of Privacy Practices:** I have received notice of the Privacy Practices of Premier Primary Care Physicians and I have been

Signature of Patient/Guardian/Guarantor \_\_\_\_\_ Date \_\_\_\_\_