

Patient Registration Form



Patient Information	Last Name		First Name		M.I.	Previous Name(if applicable)		
	Mailing Address			Apt#	City		State	Zip
	Home Phone		Cell Phone		Work Phone w/ext			
	Preferred contact number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell							
	Family Physician (PCP):				Birth Date		Sex	
	Marital Status:				Social Security Number			
	Employer Name		Employer Address			City		State Zip
In Case of Emergency	Name of emergency contact			Relationship to Patient				
	Address			Home Number		Work Number		
Insurance & Payment Information	Person responsible for the bill (ONLY IF DIFFERENT THAN THE INSURED):			Date of Birth		Social Security #	Phone:	
	Address of Person Responsible			Employer of Person Responsible				
	City, State Zip			Relationship to Patient				
	Primary Medical Insurance				Secondary Medical Insurance			
	Ins. Co. Name _____			Ins. Co. Name _____				
	Policy Holder's Name _____			Policy Holder's Name _____				
	Policy Holder's address if not same. _____			Policy Holder's address if not same. _____				
Policy Holder's Birth Date _____		Policy Holder's Social # _____		Policy Holder's Birth Date _____		Policy Holder's Social # _____		
Patient Relationship to Policy Holder _____			Patient Relationship to Policy Holder _____					
Employer Name _____			Employer Name _____					
Additional Information	Physical Address (if different than mailing)			Apt#	City		State	Zip
	Email Address:			Can we leave info on your home answering machine regarding your medical care and test results? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	VFC Eligibility: Are you one of the following? <input type="checkbox"/> Enrolled in Medicaid <input type="checkbox"/> Have no health insurance <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Underinsured (health insurance does not pay for immunizations)			OK to leave message at work on personal voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No				
				Preferred Pharmacy Name and Location:				
	If you wish to give Primary Health Medical Group permission to discuss your medical information with someone other than yourself, ask one of our staff members for a Release of Information Authorization Form.							

I have read and agree to Primary Health Medical Group's (PHMG) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby authorize PHMG to furnish insured's insurance company all information (including HIV, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment) which may be requested concerning my illness or injury. I also authorize the release of information regarding work related injuries to my employer. I hereby assign to PHMG all money to which I am entitled for medical expenses related to the services performed from time to time by PHMG, but not to exceed my indebtedness to PHMG. Any money received from such insurance company over and above such indebtedness will be refunded to me when my bill is paid in full. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside billing service. If my account is sent to an outside billing service there will be a setup fee up to \$20.00 and finance charge(s) (1% per month/APR 12%). Note: Medicare patients will *not* be charged the set up fee or finance charge(s).

MEDICARE BENEFICIARIES: As a Medicare patient, I understand that interest will not be imposed on any outstanding balance. I request that payment of authorized Medicare benefits be made to PHMG. I authorize any holder of medical information about me to release to HCFA and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party	X	Date
I have reviewed a copy of Primary Health Medical Group's Privacy Notice.		
Signature	X	Date