MRN: ______________________

Appt Date: ______________________

Doctor: ______________________

REGISTRATION FORM

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)	Sex	Date of Birth / /	Marital Status	Race	Social Security Number

Patient Address	City	State	Zip Code	Patient Phone Number ( )
Patient Employer		**Occupation & Department**		
Employer Address	**City**	**State**	**Zip Code**	**Work Phone Number ( ) Ext.**

SPOUSE/GUARDIAN/NEXT OF KIN INFORMATION

Spouse or Guardian (Last, First, Middle Initial)	Date of Birth / /	Relationship to Patient ☐ Spouse ☐ Guardian ☐ Parent	Social Security Number

Spouse or Guardian Address	City	State	Zip Code	Spouse/Guardian Phone Number
Spouse or Guardian Employer				**Work Phone Number ( ) Ext.**
Spouse or Guardian Employer Address	**City**	**State**	**Zip Code**	

BILLING INFORMATION/GUARANTOR

Guarantor Name (Last, First, Middle Initial)	Patient Relationship to Guarantor ☐ Self ☐ Dep Child ☐ Spouse ☐ Student ☐ Other	Guarantor SS Number

Guarantor Address	City	State	Zip Code	Guarantor Phone Number
Guarantor Employer		**Department**		
Guarantor Employer Address	**City**	**State**	**Zip Code**	**Work Phone Number ( ) Ext.**

INSURANCE INFORMATION

Subscriber Name					Expiration Date	Relationship to Insured
Primary Insurance Company	Address	City	State	Zip Code		☐ Self ☐ Spouse
Primary Insured Name	Group Number	Policy #, ID #, or Certificate #		Effective Date		☐ Child ☐ Other INS. #
Secondary Insurance Company	Address	City	State	Zip Code		☐ Self ☐ Spouse
Secondary Insured Name	Group Number	Policy #, ID #, or Certificate #		Effective Date		☐ Child ☐ Other INS. #

Do you have Medicare? ☐ Yes ☐ No	Medicare Number	State	Do you have Medicaid? ☐ Yes ☐ No	Medicaid Number	State

Is this visit related to an accident? ☐ Auto ☐ Job Related | Date of Injury

Referring Physician Name	Address	City	State	Zip Code	Phone Number

Who may we notify in case of emergency?	Relationship	Phone Number ☐ Work ☐ Home

Do you have a Living Will? ☐ Yes ☐ No Do you need information on a Living Will? ☐ Yes ☐ No

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST FOR PHOTOCOPYING

I authorize release of any medical information necessary to process this claim. I also authorize the direct payment of any benefits due me for the described services to Premier Internal Medicine, P.C. I understand that I am financially responsible for paying any unpaid balance and will be responsible for the entire bill if claims are not covered by my insurance.

______________________________ ___/___/___

Patient or Legal Guardian Signature Date

AUTHORIZATION TO LEAVE MESSAGE:
I authorize the treating physician's office to leave a message at my place of work, on my answering maching, email, or with another person answering my phone.

______________________________ ___/___/___

Patient or Legal Guardian Signature Date