Premier Health
Premier Physician Network

Work-Related/Auto/Other Injury:
Use Supplement Info Form

Minor Registration Form

PATIENT INFORMATION:

*Patient Name _____ *SSN: _____
Last First Full Middle 123-45-6789

*Sex ☐ Male ☐ Female Date of Birth ____/____/____ Aliases/Nicknames _____

*Street Address/P.O. Box _____ *City, State, Zip _____

County _____ Home Phone (____) _____ Email address _____

Who Does Child live with? _____ Relationship to child _____

Name of Legal Guardian, if different _____ Legal Guardian Phone _____

Language _____ Ethnic Group _____ Patient Race _____

Special Needs Hearing _____ Language _____ Speech _____ Vision _____ Other _____

EMERGENCY CONTACT:

Mother/Legal Guardian Name _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

Father/ Legal Guardian Name _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

Name _____ Phone (____) _____ Alternate Phone (____) _____ Relation to Patient _____

RESPONSIBLE PARTY (GUARANTOR): Check if Same as Patient ☐

*Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

*Name _____ *SSN: _____
Last First Full Middle 123-45-6789

*Street Address/P.O. Box _____ *City, State, Zip _____

*Sex: ☐ Male ☐ Female *Date of Birth ____/____/____ *Home Phone (____) _____ Work Phone (____) _____

*Employer _____ *Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Self-employed ☐ Unemployed ☐ Active Military

Employer Street Address _____ City _____ Zip _____

INSURANCE/POLICY HOLDER INFORMATION (SUBSCRIBER): Please present insurance cards to receptionist

*Primary Insurance _____ *Effective Date ____/____/____

*Policy Holder Name _____ *SSN: _____
123-45-6789

*Member ID _____ *Group Number _____ *Policy Holder Birthdate ____/____/____

*Sex: ☐ Male ☐ Female *Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other *Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

*Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Self-employed ☐ Unemployed ☐ Active Military Employer _____ Employer Phone (____) _____

Please complete the reverse side.

* Required fields

SECONDARY INSURANCE:

Secondary Insurance_____ Effective Date____/____/_____

Policy Holder Name_____ *SSN: _____
123-45-6789

*Member ID_____ *Group Number_____ *Policy Holder Birthdate____/____/_____

*Sex: ☐ Male ☐ Female

*Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

*Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

*Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Self-employed ☐ Unemployed ☐ Active Military

Employer_____ Employer Phone (____)_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ CareFinders ☐ Friends/Family ☐ Physician ☐ Advertisement ☐ Other_____

Whom may we thank for your referral to this office?_____
Name Address (if known) Phone #

Authorization for Treatment and Disclosure of Information for Treatment, Payment, and Operations

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of Premier Physician Network (PPN). I realize that if a medical procedure or surgery is required, I will be given additional information.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I consent to PPN using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that PPN reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager. I have the right to revoke this consent by notifying PPN in writing, except to the extent that Premier Physician Network has taken action in reliance on my consent.

I hereby authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to PPN any information regarding my Medicare claims under title XVII and XIX of the Social Security Act.

FINANCIAL AGREEMENT

I realize the bill is my responsibility. I assign and authorize payments be made directly to PPN of all insurance benefits and agree to pay any balance due. I agree, in order for PPN to service my account or to collect any amounts I may owe, PPN may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, and may also contact me by sending text messages or e-mails, using any e-mail address I provide to use which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

_____ ____/____/____ ____/____/_____
Signature of patient or patient's representative Date Date of Birth

_____ _____
Printed name of patient or patient's representative Relationship to patient or representative's authority to act for the patient.

Siblings seen at this office:

Name	**Birthdate**
1	/____/____
2	/____/____
3	/____/____
4	/____/____