Submit by Email | Print Form

WELCOME TO PREMIER FAMILY MEDICAL, PC. Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We are always happy to help.

PERSONAL INFORMATION

PATIENT NAME (Last / First / MI)

TODAY DATE ____/____/____ (Month / Day / Year) | Social Security #_____-_____-_____ (required for all adults) | Birth Date ____/____/____ (Month / Day / Year)

Sex ☐ Male ☐ Female | Wishes to be called as " "

Home Phone _____-_____-_____ | Work Phone _____-_____-_____ | Cellular _____-_____-_____ | Pager _____-_____-_____

Address (street) | apt / unit # | City | State | Zip

E-mail address @ | Employer | Occupation

Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated | Referred by

Where do you prefer to receive calls? ☐Home ☐Work ☐Cell ☐Pager ☐Other: _____-_____-_____ ☐OK to leave message

What is the best time to reach you? Time _____ : _____ Days ☐MON ☐TUE ☐WED ☐THU ☐FRI

In case of an emergency, whom should we contact? (Last / First / MI)

Relationship | Work # | Home # | Cell # | Pager #

RESPONSIBLE PARTY

NAME OF RESP. PARTY (Last / First / MI)

Relationship to patient ☐ Self (if Self, go to "PRIMARY INSURANCE" section) ☐ Spouse ☐ Parent ☐ Relative ☐ Friend ☐ Employer

Social Security #_____-_____-_____ (required for all adults) | Birth Date _____/_____/_____ (Month / Day / Year)

Home Phone _____-_____-_____ | Work Phone _____-_____-_____ | Cellular _____-_____-_____ | Pager _____-_____-_____

Address (street) | apt / unit # | City | State | Zip

E-mail address @ | Employer | Occupation

Sex ☐ Male ☐ Female | Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

PRIMARY INSURANCE

NAME OF INSURED (Last / First / MI)

Insured birth date | Relationship to patient | Soc. Sec.#

Name of insurance company | Insurance Co. address

Plan type | ID# | Group#

Insured employer | Date employed | Occupation

Deductible $ | Amount already used $

SECONDARY INSURANCE

NAME OF INSURED (Last / First / MI)

Insured birth date | Relationship to patient | Soc. Sec. #

Name of insurance company | Insurance Co. address

Plan type | ID# | Group#

Insured employer | Date employed | Occupation

Deductible $ | Amount already used $

Payment is due at time of service unless Premier Family Medical, hence forth known as PFM, has a contract with your insurance carrier. In that case PFM will submit the claim three times. If there is no response after the third submission, the charge will become the responsibility of the patient or his guarantor. If PFM submits a claim for services rendered to the patient identified above, you will obligated to pay PFM for any amounts identified by you carrier as patient responsible, including copayments, deductibles and coinsurance. You are also responsible to pay PFM for any services deemed ineligible or not covered by your insurance plan. PFM will not bill you for contracted fee adjustments. Copayments are due at time of service as well as all other outstanding balances due for the above-mentioned patient and/or any other immediate family member.

STATEMENT OF PATIENT OR GUARANTOR (please note: MUST BE SIGNED in order to be seen by a health care provider!)

I have read, understand and accept the above agreement. I authorize and request my insurance company to pay directly to PFM insurance benefits otherwise payable to me. If I receive insurance benefit related to services provided by PFM, I will promptly assign and forward them to PFM. If there is a balance due after my insurance processes the claim, I will pay it in full within 30 days of the monthly billing date. If my balance becomes overdue, a late charge of 1.5% will be assessed each month. I realize that failure to keep this account current may result in PFM being unable to provide additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any further outstanding balances. I also agree to pay $10.00 administrative processing charge if I neglect to pay my copayment at the time of service and a charge of $50.00 if I miss my appointment without providing at least 24 hours notice.

PATIENT OR GUARANTOR SIGNATURE _____ DATE_____/_____/_____