SUBMIT

PREMIER HEALTH CENTER

REGISTRATION FORM

PLEASE PRINT

PATIENT NAME:

First_____ Middle _____ Last_____

MAILING ADDRESS:

_____ CITY_____ST _____ZIP CODE_____

HOME_____ CELL _____WORK_____

DATE OF BIRTH_____ AGE _____ PATIENT SS#_____

MARITAL STATUS: Single Married Separated Divorced Widowed SEX☐M F☐

INSURANCE INFORMATION ☐ ☐ ☐ ☐ ☐ CO PAY _____

SUBSCRIBER'S NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER'S SS#_____ DOB_____

PRIMARY INSURANCE _____CONTRACT #_____GROUP_____

SECONDARY INSURANCE _____CONTRACT #_____GROUP_____

EMPLOYER_____

PERSON RESPONSIBLE FOR BILL _____PHONE #_____

****IN CASE OF EMERGENCY....NAME OF CLOSEST RELATIVE OR FRIEND****

NAME _____PHONE NUMBER _____

NAME _____PHONE NUMBER_____

I consent to treatment necessary for the above named patient. I acknowledge full financial responsibility for services rendered by Premier Health Center. I agree to pay all reasonable attorney fees and 28% collection costs in the event of default of payment. I have read and fully understand the above consent for treatment and financial responsibility.

SIGNATURE OF PATIENT/GUARDIAN_____DATE_____