



REGISTRATION FORM

PATIENT INFORMATION:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SS # (last 4 digits only) – OPTIONAL	
STREET ADDRESS/P.O. BOX			CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE		SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> S <input type="checkbox"/> D
EMAIL ADDRESS			RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		
EMPLOYER	EMPLOYER STREET ADDRESS		CITY	ZIP	
PRIMARY PHYSICIAN			NAME OF CUSTODIAL PARENT		

RESPONSIBLE PARTY: (If different from above)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SS # (last 4 digits only) – OPTIONAL	
STREET ADDRESS/P.O. BOX			CITY	STATE	ZIP
EMAIL ADDRESS	HOME PHONE	WORK PHONE	CELL PHONE		
EMPLOYER	EMPLOYER STREET ADDRESS		CITY	ZIP	

EMERGENCY CONTACT: (Person not living with you)

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

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

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F	EMPLOYER
POLICY HOLDER BIRTHDATE	POLICY NUMBER	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other		WORK PHONE

SECONDARY INSURANCE:

SECONDARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F	EMPLOYER
POLICY HOLDER BIRTHDATE	POLICY NUMBER	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other		WORK PHONE

ADVANCED DIRECTIVES:

Do you have an advanced directive (living will)?	Yes	No
If yes, at which hospital is it filed? _____		

HOW DID YOU HEAR ABOUT OUR OFFICE?

1. <input type="checkbox"/> CareFinders 2. <input type="checkbox"/> Friends/Family 3. <input type="checkbox"/> Physician 4. <input type="checkbox"/> Advertisement 5. <input type="checkbox"/> Other _____		
Whom may we thank for your referral to this office? _____		
Name	Address (if known)	Phone #

Please complete the reverse side.

Premier HealthNet (PHN)

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 PHN. 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 PHN 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 PHN 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 PHN in writing, except to the extent that Premier HealthNet has taken action in reliance on my consent.

MEDICARE PATIENTS ONLY-PLEASE COMPLETE THIS SECTION

1. Are you currently working? Yes No
If yes, employer? _____
2. Do you have insurance through your employer? Yes No
3. Is your spouse currently working? Yes No
If yes, employer? _____
4. Do you have insurance through your spouse's employer? Yes No
5. Is your visit related to an accident or injury? Yes No
If yes, do you have any other insurance responsibilities for this bill? Yes No

If you answered yes to any questions above, please provide insurance information to the staff.

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 PHN 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 PHN of all insurance benefits and agree to pay any balance due.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or representative's authority to act for the patient.