



PATIENT INFORMATION:

*Patient Name: _____ *SS #: _____
Last First Full Middle last 4 digits only

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

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

County: _____ *Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Email Address: _____ Marital Status: Married Widowed Single Divorced
 Legally Separated Significant Other

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

Occupation: _____ Primary Physician: _____

Name of Legal Guardian: _____

Preferred Language: _____ Ethnic Group: _____ Race: _____

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

EMERGENCY CONTACT:

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

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

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

*Name: _____ *Relationship to Patient: Self Spouse Parent Child Other
Last First Full Middle

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

*SS #: _____ *Sex: Male Female *Date of Birth: ____/____/____ *Home Phone: (____) _____ Work Phone: (____) _____
last 4 digits only

*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: _____

*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: (____) _____

SECONDARY INSURANCE:

Secondary Insurance: _____ Effective Date: ____ / ____ / ____ Policy Holder Name: _____

*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: (____) _____

ADVANCED DIRECTIVES: (circle if applicable)Do you have an advanced directive? Living will: Y / N DNR: Y / N Durable Power of Attorney for health care: Y / N

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 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.

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