Prime Health
MEDICAL CENTER

Patient Registration Form

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)

Mailing Address: Apt #

City/State/Zip: Email Address:

Home Phone:	Cell Phone:	Work Phone:

Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:
(Please Select Only One Option) ☐ Voice ☐ Text

If Voice, Please Select Preferred Number:
☐ Home ☐ Cell ☐ Work

Family Physician or Pediatrician:	Date of Birth:	Sex: ❑ Male ❑ Female
Marital Status:	Social Security #:	
Employer Name:	Emergency Contact Name:	
Emergency Contact Phone #:	Relationship to Patient:	

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:

Can we leave a message regarding your medical care & test results?
☐ Yes ☐ No

Race (please select):
☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Language (please select one):
☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil)
☐ Sign Language ☐ Spanish ☐ Russian ☐ Other

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Prime Health Medical Center (PHMC) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PHMG all money to which I am entitled for medical expenses related to the services performed from time to time by PHMC, but not to exceed my indebtedness to PHMC. I authorize PHMC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from PHMC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PHMC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Prime Health Medical Center's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X _____ **Date:**

Printed Name of Responsible Party: X _____ **Date:**