PREMIER PHYSICIANS

Name: (Last, First, MI)	Age:	Sex: M F	Birth Date:
Street Address:	City:	Zip	SS#
Mailing Address:	City:		Zip:
Home & Cell Phone:	Email Address:		
Employer:	Address:		Work Phone:
Email Address:	Occupation:		Referred by:

SPOUSE OR LEGAL GUARDIAN

Name: (Last, First, MI)	Legal Guardian: Yes No		Birth Date:
Street Address:	City:		Zip:
Home & Cell Phone:	Work Phone:	Email Address	SS#:
Employer:	Address:		Email Address:

In Case of Emergency (Friend or Relative not listed above. ONE MUST BE LOCAL)

Name (1): (Last, First)	Address:	
Home & Cell Phone:	Work Phone:	Relation:
Name (2): (Last, First)	Address:	
Home & Cell Phone:	Work Phone:	Relation:

INSURANCE INFORMATION (A copy of ALL Insurance cards is required for filing purposes.)

Primary Insurance:		Name of Insuree & SS#:
Group #:	Insuree's DOB:	Insurance ID#
Secondary Insurance:		Name of Insured & SS#:
Group #:	Insuree's DOB:	Other Insurances (cont on back):
Medicare? Yes or No	Medicare #	SS#

Optional: **Decline** ☐

Married Status: ☐ Single ☐ Married ☐ Divorced **Language:** ☐English ☐Spanish Other_____

Race: ☐White/ Hispanic ☐ African American ☐Asian ☐Native American ☐ Other _____

Ethnicity: ☐White American ☐Hispanic/ Latino ☐African American ☐ Native American ☐Indian American ☐ Chinese American ☐Other _____

Assignment of Benefits

I authorize Premier Physicians to release any medical information that may be necessary to process medical/surgical claims for myself or my dependents. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and other health plans to issue payments on my behalf to Premier Physicians. I understand that I am responsible for amounts not covered by insurance. This order will remain in effect until revoked by me in writing.

_____ _____

DATE SIGNATURE of PATIENT (or Parent/Legal Guardian if Patient is a minor)