

**PRIME Healthcare, PC**

**PLEASE COMPLETE ALL PORTIONS OF THIS FORM**

**Patient Information**

SSN# \_\_\_\_\_ Employer: \_\_\_\_\_  
Last Name: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_ Occupation: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
Sex: (Male) \_\_\_ (Female) \_\_\_ Marital Status: (Single) \_\_\_ (Married) \_\_\_ (Divorced) \_\_\_ (Widowed) \_\_\_  
Address: \_\_\_\_\_ Primary Care Dr: \_\_\_\_\_  
City: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Home Telephone #: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_ Spouses Name: \_\_\_\_\_  
Spouses Date of Birth: \_\_\_\_\_ Spouses Employee: \_\_\_\_\_

**Pharmacy Name & Phone Number:** \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Primary Insurance**

Name of Insurance Co: \_\_\_\_\_  
Effective Date of Coverage: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_  
Subscriber's SSN#: \_\_\_\_\_

**Secondary Insurance**

Name of Insurance Co: \_\_\_\_\_  
Effective Date of Coverage: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_  
Subscriber's SSN#: \_\_\_\_\_

I hereby authorize Prime Healthcare, PC to leave answering machine/voicemail messages or give messages regarding my visit to (name of person) \_\_\_\_\_ either at home or work.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I hereby authorize direct payment of medical/surgical benefits to PRIME Healthcare, PC for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I hereby authorize PRIME Healthcare, PC, its agents and representatives, to access information regarding my person, whereabouts and medical history and to release all necessary information to my insurance company regarding my medical history, examinations, and treatment for the purposes of processing my insurance coverage. A photocopy of my signature is as valid as the original.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Person if not the patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_