

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 Employer: _____

Emergency Contact (other than spouse)

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: _____

Secondary Insurance

Name of Insurance Co: _____
Effective Date of Coverage: _____
Policy Number: _____
Group Number: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____

Local Pharmacy Name: _____ Phone: _____

Mail Order Pharmacy Name: _____ Phone: _____

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: _____