Premier Family Medicine, LLC

Registration & Change of Information Form

Please NOTE: All questions are important. We only ask what we need to know or what is required by the Federal Government. Complete ALL boxes, writing "n/a" in a box that is not applicable.

First Name	**Middle**	**Last Name**	**Suffix** Jr Sr III ____ n/a	**Salutation** Mr Mrs Ms Dr _____
Date of Birth	**Gender** F M	**Social Security #**		**Marital Status** Single Married _____
Street Address		**City, State ZIP**		
Email Address ***(to activate your patient portal account)***			**Language Preference*** *(note: staff only speaks English)* English Spanish _____	
Home Phone	**Cell Phone (accept text? Yes No)**	**Work Phone**	**Contact Preference** Email Home Phone Cell Phone Work Phone	
Race *(census bureau category)** White Black or African American White Hispanic Black Hispanic Unknown Other _____		**Ethnicity*** Not-Hispanic Hispanic or Latino	**Emergency Contact** Name, Relationship, Telephone	

Race, Ethnicity & Language Preference, have no impact on your care but we are required by the Federal Government & Meaningful Use to ask. Race & Ethnicity categories are as defined by the Federal Government.

Other Immediate Family Members seen at Premier Family Medicine : *(spouses & minor children living at the same address)*

Name: _____ M/F DOB: _____ | Name: _____ M/F DOB: _____

Name: _____ M/F DOB: _____ | Name: _____ M/F DOB: _____

Name: _____ M/F DOB: _____ | Name: _____ M/F DOB: _____

Responsible Party (Guarantor):

Patient Relationship to Guarantor: Self Spouse Child Other	**Printed Name of Guarantor:** *(if not Self)*	**Date of Birth:** *(if not Self)*
Street Address *(if different from Patient)*	**City, State ZIP**	**Telephone:** *(if different from Patient)*

Authorization to Release Information for Payment, Assignment of Benefits & Acceptance of Financial Responsibility:

I authorize the release of any information regarding services rendered at Premier Family Medicine to the responsible insurance carrier(s) and for Medicare related claims to the Social Security Administration, its intermediaries, carriers, or fiscal agents. I permit a copy of this authorization to be used in place of the original, or the statement, "Signature on File" to be printed on claims and request payment of medical insurance benefits be made directly to the provider.

As the Patient or the Patient's Guardian, I understand and agree that I am financially responsible for my healthcare and accept responsibility for all charges not paid directly by my insurance carrier(s).

Signature:_____Date:_____

Your signature is necessary for us to file claims on your behalf.