PREMIER HEALTH ASSOCIATES, L.L.C.

PATIENT INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security #:**
City:	**Sex:**
State: **Zip:**	**Marital Status:**
Home Phone#:	**Employer:**
Work Phone#:	**Emergency Contact:**
Cell Phone#:	**Emergency Phone#:**
Primary Care Dr:	**Emergency Relationship:**
Race: ↑African-American ↑American Indian ↑Asian ↑Hispanic ↑White ↑Other _____	***Preferred Language:*** ↑English ↑Spanish ↑Other _____ ***Ethnicity:*** _____
↑Refused to Report ↑Unreported	

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	**Email:**
City:	
State: **Zip:**	
Home Phone#:	
Work Phone#:	
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name: **Subscriber DOB:**	**Subscriber Name:** **Subscriber DOB:**
Subscriber SSN:	**Subscriber SSN:**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, when he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent if minor) Date