Patient Registration Form

Patient Information

Last Name:	First Name:	M.I.	Previous Name:
Mailing Address:		Apt #:	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	Sex: ☐ Male ☐ Female	Family Physician:	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Person responsible for the bill (ONLY IF DIFFERENT THAN THE PATIENT):

Last Name:	First Name:	
Date of Birth:	SSN #:	Phone:
Address of Person Responsible (if different from patient):		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL FIELDS BELOW):

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ **Yes** ☐ **No**
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Russian ☐ Sign Language ☐ Spanish ☐ Other

Preferred Pharmacy Location:

Insurance Information

Primary Policy Holder Information (ONLY IF DIFFERENT THAN THE PATIENT OR RESPONSIBLE PARTY):

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Relationship to Patient:	Policy Holder Relationship to Patient:
Policy Holder Address:	Policy Holder Address:

I have read and agree to Primary Health Medical Group's (PHMG) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PHMG all money to which I am entitled for medical expenses related to the services performed from time to time by PHMG, but not to exceed my indebtedness to PHMG. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PHMG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.
This office has chosen to participate in the Idaho Health Data Exchange (IHDE). If you do not wish to share your healthcare information with other medical providers you can contact the IHDE at (208)332-7253 or www.idahohde.org

I have reviewed a copy of Primary Health Medical Group's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: _____ Date_____

Printed Name of Responsible Party:_____