Patient Registration Form

Primary Health Medical Group

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred method of contact for reminder calls and other electronically generated messages: (Please select only one option) ☐ Voice ☐ Text			If Voice, please select preferred number : ☐ Home ☐ Cell ☐ Work
Date of Birth:	Sex: ☐ Male ☐ Female		Family Physician or Pediatrician:
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 FROM PATIENT)**

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Additional Information **(PLEASE FILL OUT ALL SECTIONS 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 ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ 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) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

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 authorize PHMG to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. 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. A $15.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging as a communication method, I certify that Primary Health Medical Group is not liable for any wireless charges I may incur and acknowledge that they may communicate patient information via text message.

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: **X** _____ **Date:**

Printed Name of Responsible Party: **X** _____ **Date:**