Primary Health Medical Group

Patient Registration Form

Patient Information

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

Insurance & Payment Information

Person responsible for the bill (**ONLY IF DIFFERENT THAN THE INSURED**):		
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		City/State/Zip:
Employer of Person Responsible:	Relationship to Patient:	

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Address if not same:	Policy Holder's Address if not same:
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:
Employer Name:	Employer Name:

Additional Information

Physical Address (if different than mailing):	City/State/Zip:
Email Address:	Can we leave a message regarding your medical care & test results? ☐ Yes ☐ No

Race (please select one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ White ☐ 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 Name & Location:

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 authorize PHMG to furnish insured's insurance company all information (including HIV, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment) which may be requested concerning my illness or injury. I also authorize the release of information regarding work related injuries to my employer. 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. Any money received from such insurance company over and above such indebtedness will be refunded to me when my bill is paid in full. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside billing service. If my account is sent to an outside billing service there will be a setup fee up to $20.00 and finance charge(s) (1% per month/APR 12%). Note: Medicare patients will *not* be charged the set up fee or finance charge(s).

MEDICARE BENEFICIARIES: As a Medicare patient, I understand that interest will not be imposed on any outstanding balance. I request that payment of authorized Medicare benefits be made to PHMG. I authorize any holder of medical information about me to release to HCFA and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party: X ______________________ Date:

I have reviewed a copy of Primary Health Medical Group's Privacy Notice.

Signature: X ______________________ Date: