PREMIER MEDICAL ASSOCIATES, P.C. — PEDIATRIC PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME		
ADDRESS		
CITY		
STATE	ZIP	
HOME PHONE	WORK PHONE	
DATE OF BIRTH		❑ MALE ❑ FEMALE
SOCIAL SECURITY NO.		
MOTHER'S NAME		
FATHER'S NAME		
STUDENT STATUS	❑ FULL-TIME	❑ PART-TIME
REFERRING PHYSICIAN		

SCHOOL

NAME
ADDRESS
PHONE

GUARANTOR INFORMATION

NAME		
ADDRESS		
CITY		
STATE	ZIP CODE	
HOME PHONE	WORK PHONE	
DATE OF BIRTH		❑ MALE ❑ FEMALE
SOCIAL SECURITY NUMBER	RELATIONSHIP	
EMPLOYER		
ADDRESS OF EMPLOYER		
EMPLOYMENT STATUS	❑ FULL-TIME ❑ PART-TIME	❑ NOT-EMPLOYED
RETIREMENT DATE		

EMERGENCY CONTACT

NAME OF EMERGENCY CONTACT
RELATIONSHIP
PHONE NO. OF EMERGENCY CONTACT

GUARDIANSHIP

NAME OF GUARDIAN
ADDRESS
PHONE NO. OF GUARDIAN

PRIMARY HEALTH INSURANCE

SUBSCRIBER'S NAME	
NAME OF INSURANCE CO.	
ADDRESS OF INSURANCE CO.	
PHONE NUMBER OF INSURANCE CO.	
SUBSCRIBER'S EMPLOYER	
SUBSCRIBER'S ID NUMBER	SUBSCRIBER'S GROUP NUMBER
RELATIONSHIP TO PATIENT ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER	
EFFECTIVE DATE	SUBSCRIBER'S DATE OF BIRTH

SECONDARY HEALTH INSURANCE

SUBSCRIBER'S NAME	
NAME OF INSURANCE CO.	
ADDRESS OF INSURANCE CO.	
PHONE NUMBER OF INSURANCE CO.	
SUBSCRIBER'S ID NUMBER	SUBSCRIBER'S GROUP NUMBER
RELATIONSHIP TO PATIENT ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER	
EFFECTIVE DATE	SUBSCRIBER'S DATE OF BIRTH

ILLNESS / INJURY INFORMATION

WHO REFERRED YOU TO OUR PRACTICE?		
IS THIS AN	❑ ILLNESS ❑ INJURY	❑ OTHER:
WORK RELATED ❑ YES, SEE REVERSE ❑ NO		AUTO RELATED ❑ YES, SEE REVERSE ❑ NO
STATE WHERE INJURY OCCURRED		
FIRST DATE OF ILLNESS / INJURY		
FIRST DATE WORK MISSED DUE TO ILLNESS / INJURY		
DATE RETURNED TO WORK		
NATURE OF ACCIDENT	❑ *INJURED / HOME* ❑ *INJURED / SCHOOL* ❑ *INJURED / DURING RECREATION* ❑ *WORK INJURY / SELF EMPLOYED* ❑ *WORK INJURY / NOT SELF EMPLOYED* ❑ *MOTORCYCLE INJURY*	

WORKERS COMPENSATION INSURANCE

NAME OF EMPLOYER'S INSURANCE COMPANY
ADDRESS OF EMPLOYER'S COMPANY
EMPLOYEE'S SOCIAL SECURITY NUMBER
CLAIM NUMBER
DATE OF INJURY
TYPE OF INJURY
PLACE OF ACCIDENT
EMPLOYER'S INSURANCE COMPANY CONTACT
PHONE NUMBER OF EMPLOYER'S INSURANCE COMPANY

AUTO INSURANCE

SUBSCRIBER'S NAME
NAME OF AUTO INSURANCE CARRIER
ADDRESS OF AUTO INSURANCE CARRIER
RELATIONSHIP TO PATIENT ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER
CLAIM NUMBER
ADJUSTER'S NAME
ADJUSTER'S TELEPHONE NUMBER
DATE OF INJURY
TYPE OF INJURY
PLACE OF ACCIDENT
AUTO INSURANCE COMPANY CONTACT
PHONE NUMBER OF AUTO INSURANCE COMPANY

I request that payment of authorized primary health care benefits be made either to me or on my behalf to Premier Medical Associates, P.C. (PMA) for any services furnished to me by PMA. I authorize PMA to release to my primary health care insurance agent any information that is needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature: ______________________________ Date: ______________________

I request that payment of authorized secondary health care benefits, if any, be made either to me or on my behalf to Premier Medical Associates, P.C. (PMA) for any services furnished to me by PMA.

I authorize PMA to release to any secondary insurer indicated any information that is needed to determine benefits payable for services.

Signature: ______________________________ Date: ______________________

(Wording revised: 9/2003)

FOR PMA PERSONNEL ONLY:

INFORMATION VERIFIED BY: ______________________ DATE: ______________________