Premier Family Medicine, LLC

Registration & Change of Information Form

Please NOTE: All questions are important. We only ask what we need to know or what is required by the Federal Government. Complete ALL boxes, writing "n/a" in a box that is not applicable.

First Name **Middle** **Last Name**				**Suffix** Jr Sr III ____ n/a	**Salutation** Mr Mrs Ms Dr _______
Date of Birth	**Sex Assigned at Birth** F M	**Gender Identity***	**Sexual Orientation***	**Social Security #**	**Marital Status** Single Married __________
Street Address			**City, State ZIP**		
Email Address ***(to activate your patient portal account)***				**Preferred Language*** *(note: staff only speaks English)* English Spanish ____________________	
Home Phone	**Cell Phone (accept text? Yes No)**		**Work Phone**		**Contact Preference** Email Home Phone Cell Phone Work Phone
Reminder Preference: Text Cell Call Home Call Email			**Occupation:** (☐ *retired*)		
Race *(census bureau category)**** White Black or African American White Hispanic Black Hispanic Unknown Other __________________		**Ethnicity*** Not-Hispanic Hispanic or Latino Unknown	**Emergency Contact** Name, Relationship, Telephone		

****Gender Identity, Sexual Orientation, Race, Ethnicity & Preferred Language, have no impact on your care.***

We are required to ask by the Federal Government & to report aggregate practice totals.

Race & Ethnicity categories are as defined by the Federal Government.

Other Immediate Family Members seen at Premier Family Medicine : *(spouses & minor children living at the same address)*

Name: _________________________ M/F DOB: _________	Name: _________________________ M/F DOB: ________
Name: _________________________ M/F DOB: _________	Name: _________________________ M/F DOB: ________

Responsible Party (Guarantor):

Patient Relationship to Guarantor: Self Spouse Child Other	**Printed Name of Guarantor:** *(if not Self)*	**Date of Birth:** *(if not Self)*
Street Address *(if different from Patient)*	**City, State ZIP**	**Telephone:** *(if different from Patient)*

Authorization to Release Information for Payment, Assignment of Benefits & Acceptance of Financial Responsibility:

I authorize the release of any information regarding services rendered at Premier Family Medicine to the responsible insurance carrier(s) and for Medicare related claims to the Social Security Administration, its intermediaries, carriers, or fiscal agents. I permit a copy of this authorization to be used in place of the original, or the statement, "Signature on File" to be printed on claims and request payment of medical insurance benefits be made directly to the provider.

As the Patient or the Patient's Guardian, I understand and agree that I am financially responsible for my healthcare and accept responsibility for all charges not paid directly by my insurance carrier(s).

Signature:____Date:__________________________

Your signature is necessary for us to file claims on your behalf.