Premier Health & Wellness

Patient Registration

Patient Information

Last name: _____ First name: _____ MI: _____

Social security #: _____ Date of birth (MM/DD/YYYY): _____

Driver's license number: _____ Issued in what state: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Contact phone (home or cell): _____ Work phone: _____

e-Mail address: _____

Occupation: _____ Employer: _____

Employment Status: Employed Retired Unemployed Disabled Student

Patient is: ☐ Policy Holder ☐ Responsible Party

Responsible Party (if someone other than patient)

Last name: _____ First name: _____ MI: _____

Social security #: _____ Date of birth (MM/DD/YYYY): _____

Driver's license number: _____ Issued in what state: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Contact phone (home or cell): _____ Work phone: _____

e-Mail address: _____

Primary Insurance Information

Name of Insurance Carrier: _____

I.D Number : _____ Group Number: _____

Insurance Company Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

In Case of Emergency

Name of local friend or relative: _____ Relationship to patient: _____

Contact phone: _____

How were you referred to us? ☐ Friend ☐ Employer ☐ Drove-by ☐ Other: _____

Please Turn Over & Complete Other Side

Premier Health & Wellness

Patient Registration

Consent to Treatment

I voluntarily consent to receive medical and healthcare services that may include diagnostic procedures, examinations, and treatment.

Signature: _____ Date: _____

Financial Responsibility and Assignment of Benefits

I agree to pay all charges for medical and healthcare services not covered by my insurance company.

I certify that I have read this form and understand its contents.

Signature: _____ Date: _____