PRIMARY HEALTH ASSOCIATES, P.C.

My Appointment is with Dr. _____ Date: _____

PATIENT INFORMATION

PATIENT LAST NAME		DATE OF BIRTH
FIRT NAME	MI	SEX
STREET ADDRESS		MARITAL STATUS □ Single □ Married □ Widowed □ Separated □ Divorced □ Partner
CITY		SOCIAL SECURITY #
STATE	ZIP CODE	EMPLOYER/SCHOOL NAME
HOME PHONE	CELL PHONE	EMPLOYER/ SCHOOL ADDRESS
WORK PHONE		WORK OR STUDENT STATUS □ Full Time □ Part Time □ Not employed □ Self- Employed □ Active military

RESPONSIBLE PARTY

RESPONSIBLE PARTY NAME	RELATIONSHIP TO YOU	EMERGENCY CONTACT	RELATIONSHIP TO YOU
RESPONSIBLE PARTY PHONE		EMERGENCY CONTACT PHONE	
RESPONSIBLE PARTY ADDRESS, CITY,STATE, ZIP		EMERGENCY CONTACT ADDRESS, CITY,STATE, ZIP	

INSURANCE INFORMATION

(CIRCLE ONE) MEDICARE MEDICAID HMO PPO EPO POS PRIVATE NONE OTHER:_____

PRIMARY INSURANCE	EFFECTIVE DATE	SUBSCRIBER NUMBER/ID	GROUP NUMBER
POLICY HOLDER NAME	RELATIONSHIP TO YOU	POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SOCIAL SECURITY NUMBER
SECONDARY INSURANCE	EFFECTIVE DATE	SUBSCRIBER NUMBER/ID	GROUP NUMBER
POLICY HOLDER NAME	RELATIONSHIP TO YOU	POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SOCIAL SECURITY NUMBER

ELECTRONIC INFORMATION

We offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

□ YES, I WANT TO PARTICIPATE, MY EMAIL IS PROVIDED BELOW. □ NO, I DONOT WISH TO PARTICIPATE AT THIS TIME.

HOME EMAIL:

ADDITIONAL INFORMATION

Race: Which category best describes your racial background?

□ AMERICAN INDIAN OR ALASAKAN NATIVE	□ ASIAN	□ BLACK OR AFRICAN AMERICAN
□NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	□ WHITE	□ UNREPORTED / REFUSED TO REPORT

Ethnicity: How would you describe you ethnicity, such as your family background or ancestry?

□ HISPANIC OR LATINO	□ NOT HISPANIC OR LATINO	□ UNREPORTED / REFUSED TO REPORT

Preferred Language: What language do you usually speak at home?

□ ENGLISH	□ SPANISH	□ OTHER

PRESCRIPTION AND PHARMACY INFORMATION

Patients or Authorized Person's Consent -Physician requests permission to view patient's prescription history from external sources:

□ RX history consent	CONSENT SIGNATURE	□ RX HISTORY CONSENT DENIED

PHARMACY NAME	PHARMACY ADDRESS	PHARMACY PHONE

I hereby authorize and direct Primary Health Associates, P.C. and any member physician having treated me or my dependent, to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I understand that I am responsible for all co-pays, co-insurance and deductible amounts as set forth by my insurance carrier.

I understand that any personal outstanding balance that is 30 days or more past due will be subject to a finance charge of 1.5% per mo (APR 18%).

In the event my account is placed in collection status I will be responsible for all collection costs incurred in an amount not to exceed fifty percent (50%) of the unpaid balance. In addition, should any unpaid balance be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid by you as allowed by the court. All returned checks will be assessed a $35.00 returned check fee in addition to the original charge.

SIGNED: _____ DATE: _____