Premier HealthNet
Premier Health Specialists
Upper Valley Professional Corporation

REGISTRATION FORM

PATIENT INFORMATION:

*Patient Name: _____ *SS #: _____
Last First Full Middle 123-45-6789

*Sex: Male Female *Date of Birth: ___/___/___ Aliases/Nicknames: _____

*Street Address/P.O. Box: _____ *City, State, Zip: _____

County: _____ *Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Legally Separated ☐ Significant Other

*Employer: _____ *Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Self-employed ☐ Unemployed ☐ Active Military

Occupation: _____ Primary Physician: _____

Name of Legal Guardian: _____

Preferred Language _____ Ethnic Group _____ Race _____

Special Needs: Hearing_____ Language_____ Speech_____ Vision _____ Other _____

EMERGENCY CONTACT:

Name: _____ Phone: _____ Alternate Phone: _____ Relation to Patient: _____

Name: _____ Phone: _____ Alternate Phone: _____ Relation to Patient: _____

RESPONSIBLE PARTY (GUARANTOR): *Check if Same as Patient ☐

*Name: _____ *Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other
Last First Full Middle

*Street Address/P.O. Box: _____ *City, State, Zip: _____

*SS #: _____ *Sex: Male Female *Date of Birth: ___/___/___ *Home Phone: _____ Work Phone: _____
last 4 digits only

*Employer: _____ *Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Self-employed ☐ Unemployed ☐ Active Military

Employer Street Address: _____ City: _____ Zip: _____

INSURANCE/POLICY HOLDER INFORMATION (SUBSCRIBER): **Please present insurance cards to receptionist**

*Primary Insurance: _____ *Effective Date: ___/___/___ *Policy Holder Name: _____

*Member ID: _____ *Group Number: _____ *Policy Holder Birthdate: ___/___/___

*Sex: Male Female *Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other *Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

*Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Self-employed ☐ Unemployed ☐ Active Military Employer: _____ Employer Phone: _____

Please complete the reverse side.

* Required fields

SECONDARY INSURANCE:

Secondary Insurance:_____ Effective Date:____/_____/_____ Policy Holder Name:_____

*Member ID:_____ *Group Number:_____ *Policy Holder Birthdate:____/_____/_____

*Sex: Male Female *Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other *Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

*Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Self-employed ☐ Unemployed ☐ Active Military Employer:_____ Employer Phone: _____

ADVANCED DIRECTIVES: (circle if applicable)

Do you have an advanced directive? ♦ Living will: Y / N ♦ DNR: Y / N ♦ Durable Power of Attorney for health care: Y / N

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ CareFinders ☐ Friends/Family ☐ Physician ☐ Advertisement ☐ Other_____

Whom may we thank for your referral to this office?_____

Name Address (if known) Phone #

Authorization for Treatment and Disclosure of Information for Treatment, Payment, and Operations

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of PHN/PHS/UVPC. I realize that if a medical procedure or surgery is required, I will be given additional information.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I consent to PHN/PHS/UVPC using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that PHN/PHS/UVPC reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager. I have the right to revoke this consent by notifying PHN/PHS/UVPC in writing, except to the extent that Premier HealthNet, Premier Health Specialists or Upper Valley Professional Corporation has taken action in reliance on my consent.

I hereby authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to PHN/PHS/UVPC any information regarding my Medicare claims under title XVII and XIX of the Social Security Act.

FINANCIAL AGREEMENT

I realize the bill is my responsibility. I assign and authorize payments be made directly to PHN/PHS/UVPC of all insurance benefits and agree to pay any balance due.

_____ _____/_____

Signature of patient or patient's representative Date Date of Birth

_____ _____

Printed name of patient or patient's representative Relationship to patient or representative's authority to act for the patient.