PriMed
Physicians United For Patient Care

PATIENT INFORMATION: This section refers to the PATIENT ONLY.

Social Security #:	If Employed, Employer:
Last Name:	Address:
First Name: MI:	City: State: Zip Code:
Nickname / Alias:	If Student: Full-Time Part-Time
Address:	Name of School:
City: State: Zip Code:	Allergies:
Home Phone: ( )	Referred by:
Work Phone: ( ) Ext.	Cell Phone: ( )
Birth Date (mm/dd/yyyy):	Email Address:
Gender: Male Female	Driver's License #/State:
Marital Status: S M W D	Emergency Contact (Name, Number & Relationship of closest relative NOT living with you :

RESPONSIBLE PARTY: This section refers to the PERSON/PARTY WHO SHOULD RECEIVE THE BILL.

Relationship to PATIENT: Self (skip to next section) Parent Spouse Employer Other:

Social Security #:	If Employed, Employer:
Last Name:	Address:
First Name: MI:	City: State: Zip Code:
Nickname / Alias:	If Student: Full-Time Part-Time
Address:	Name of School:
City: State: Zip Code:	Gender: Male Female
Home Phone: ( )	Cell Phone:
Work Phone: ( ) Ext.	Email Address:
Birth Date (mm/dd/yyyy):	Driver's License #/State:

SUBSCRIBER INFO: This section refers to the PERSON WHOSE NAME THE INSURANCE IS LISTED.

Relationship to PATIENT: Self (skip to next section) Parent Spouse Employer Other:

Social Security #:	If Employed, Employer:
Last Name:	Address:
First Name: MI:	City: State: Zip Code:
Nickname / Alias:	If Student: Full-Time Part-Time
Address:	Name of School:
City: State: Zip Code:	Gender: Male Female
Home Phone: ( )	Cell Phone:
Work Phone: ( ) Ext.	Email Address:
Birth Date (mm/dd/yyyy):	Driver's License #/State:

INSURANCE COVERAGE INFORMATION: Please include all numbers on your card(s).

Primary Insurance Coverage	
Policy Holder's Last Name:	ID Number:
Policy Holder's First Name:	Group/Member/Policy Number:
Insurance Company Name:	Effective Dates:
Claim Address:	
City: State: Zip Code:	

Secondary Insurance Coverage	
Policy Holder's Last Name:	ID Number:
Policy Holder's First Name:	Group/Member/Policy Number:
Insurance Company Name:	Effective Dates:
Claim Address:	
City: State: Zip Code:	

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I hereby give authorization for performance of medical treatment or procedures as may, in the judgement of my attending physician, be deemed necessary. I authorize the office of PriMed, L.L.C. to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, co-payment, deductible, and noncovered services.

Date ____________ Signature of Patient or Authorized Person ____________

PATIENT AGREEMENT

I agree to pay you your regular charges for medical services rendered. My health insurance benefits may pay all or part of your charges. I agree to pay those charges which are not paid by my health insurance. If I do not pay your bill, I agree to pay you your collection costs including attorney's fees and court costs (*there will be a $20 charge for all returned checks*).

Date ____________ Signature of Patient or Authorized Person ____________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to PriMed, L.L.C. for any services furnished me by the physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date ____________ Signature of Beneficiary ____________

MEDIGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made either to me or on my behalf to PriMed, L.L.C. for any services furnished me by that physician/supplier. I authorize any holder of Medicare information about me to release to my Medigap Insurer any information needed to determine these benefits payable for related services.

Date ____________ Signature of Beneficiary ____________