Premiere Perinatal Associates, PA
Patient Registration

Date: _____

Patient Information:

Name: _____ Home Address: _____
(Last, First, Middle) (Street Address)

Social Security Number: _____ _____
(City, State & Zip Code)

Date of Birth: _____ Sex: _____

Marital Status: Single Married Divorced Widowed Email Address: _____

Employer: _____ Home Phone: _____

Work Phone: _____ Alternative Phone: _____

Insurance/ Responsible Party Information:

Subscriber Name: _____ Relationship to Patient: Self Spouse Dependant
(Last, First, Middle)

Subscribers Social Security Number: _____ Subscribers Date of Birth: _____

Insurance Company: _____ Insurance Phone: _____

Policy Number: _____ Policy Type: _____

Group Number: _____ Insurance Claims Address: _____

Secondary Insurance Information:

Subscriber Name: _____ Relationship to Patient: Self Spouse Dependant
(Last, First, Middle)

Subscribers Social Security Number: _____ Subscribers Date of Birth: _____

Insurance Company: _____ Insurance Phone: _____

Policy Number: _____ Policy Type: _____

Group Number: _____ Insurance Claims Address: _____

Emergency Contact Information:

Name: _____ Relationship to Patient: _____
(Last, First, Middle)

Phone: _____ Alternative Phone: _____

The undersigned patient or individual acting on behalf of the patient agrees as follows:

- I authorize physician/ physician group to render needed treatment to the above named patient.
- I authorize physician/ physician group to release any medical or other information, as required in the course of examination or treatment, to process patient's claims.
- I authorize my insurance benefits to be paid directly to the treating physician/ physician group. I understand that I am responsible for charges not covered by my insurance.
- I understand that I am responsible for all charges (copayments, deductable, coinsurance & any non covered services) incurred through physician/ physician group. Payment is expected at the time of visit.

Signature: _____ Date: _____