PREMIER PRIMARY CARE
NEW PATIENT APPLICATION

Patient's Information

Marital Status: □Married □Single □Divorced □Widowed

Last Name:	First Name/Middle Initial:
Address Line1:	Date of Birth: Gender: M or F
Address Line 2:	Home Phone:
City:	Work Phone:
State: Zip Code:	Cell Phone:
Race: Ethnicity:	Social Security #:
Guarantor if applicable:	Relationship to Guarantor:
Preferred Pharmacy:	Driver License State: #:
Occupation/Employer:	Email Address:
Previous Physician:	Reason for Leaving:

List of current medical conditions:

Complete list of ALL medications taken in the past year:

MEDICATIONS	DOSE (MG)

Emergency Contact Information

Last Name:	First Name:
Relationship:	Home Phone:
Work Phone:	Cell Phone:

HIPAA Disclosure (Release of Protected Health Information)

Name:	Name:
Relationship:	Relationship:
Phone:	Phone:

Subscriber Information (Please provide all applicable insurance information. Not providing all of your insurance information will result in a delay in making your first appointment.

Last Name:	First Name/Middle Initial:
Address Line 1:	Date of Birth: Gender: M or F
Address Line 2:	Home Phone:
City:	Work Phone:
State: Zip Code:	Cell Phone:
Social Security #:	Email Address:
Primary Insurance Company:	Contract ID #:
Subscriber Name:	Relationship:
Group #:	Phone # on Back of Card:
Secondary Insurance Company:	Contract #:
Subscriber Name:	Relationship:
Group #:	Phone # on Back of Card:

CONSENT FOR EXAMINATION, MEDICAL TREATMENT AND CONDITIONS OF EXAMINATION

Consent is hereby given to perform any and all examinations, tests, procedures and treatments necessary and/or advisable; and in an emergency, without the presence of parents or responsible adults. I hereby authorize examination and treatment of the above-named patient by the physicians and physician extenders employed by Premier Primary Care. I realize that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this practice.

INFORMATION CONCERNING FILING A CLAIM WITH YOUR INSURANCE COMPANY

If we participate with your primary insurance, Premier Primary Care will gladly file a claim for you. We will allow your insurance company up to 45 days from the date of service to pay the claim. If your insurance company fails to fully compensate Sharma Family Medicine & Consulting PC within this time frame, any unpaid balance becomes your sole responsibility.

AUTHORIZATION TO FILE INSURANCE CLAIMS, TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Premier Primary Care to file insurance claims for services and supplies rendered to and for the patient.
I authorize Premier Primary Care to release information, including my medical and billing information, to referring or consulting doctors and to my insurance company. The transmission of all information may be done electronically, including the internet.
I authorize that payment of all third-party benefits otherwise payable to me be made directly to Sharma Family Medicine & Consulting PC.
I assign to Sharma Family & Consulting PC all payments for medical services and supplies.

I understand that I am financially responsible to Premier Primary Care & Sharma Family Medicine & Consulting PC for the above-named patient(s) if my insurance company fails to fully compensate Premier Primary Care & Sharma Family Medicine & Consulting PC, any unpaid balance becomes my sole responsibility. I agree to pay all amounts not covered or paid by a third-party payer within 30 days after notification from Premier Primary Care and/or a billing company acting on its behalf. I agree to pay all costs of collection, including attorney's fees and agrees to pay the legal rate of interest on the account until paid in full.

AGREEMENT AS TO CO-PAYMENTS, NON-COVERED OR NON-PAID SERVICES AND GUARANTEE OF PAYMENT

I understand that Premier Primary Care cannot bill for co-payments. Any co-payments or payments for non-covered services are due at the time medical services are provided. I acknowledge that the above information is correct and that I am responsible for the balance on my account for any services not covered or not paid by my insurance plan.

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Patient Signature Date

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Witness Signature Date