PREMIER INTERNISTS - PATIENT INFORMATION

Please Print Clearly

Name_____ ____/____/____
Last First Middle Initial D.O.B.

Insured Name_____ ____/____/____
D.O.B.

Gender __M __F Race_____Declined ___ Ethnicity_____ Declined ___

Preferred Name_____Declined___ Gender identity_____ Declined___

Preferred Pronouns_____Declined____ Sexual Orientation_____ Declined___

Primary Language _____ Declined____

Marital Status __S __M __W __D __SEP

Home Phone ( ) _____ Mobile Phone ( )_____

Email Address _____(for Patient Portal)

Home Address _____
Street Apt. #

City_____ State_____ Zip_____

___ Retired ___Working Work Phone_____

Employer Name _____

Emergency Contact _____

Relation _____ Phone number ( )_____

Primary Insurance _____ID #_____ Group #_____
Secondary Insurance _____ID #_____ Group #_____

Pharmacy name and phone number:_____

Your signature attests that you have received and accept the terms of Form MMG-2, Patient Consent to the Use & Disclosure of Health Information on this date. (This is posted in the lobby or you can request the handout) Your signature also allows us to speak with anyone listed on page 2, the HIPAA release portion of this document.

Signature Date