Patient Registration Form

Patient Information

Last Name:	First Name:	MI:	Previous Name (If applicable)
Mailing Address:			
City/State/Zip			
Home Phone:	Cell Phone:	Work Phone:	

Preferred Method of Contact for Reminder Calls and Orth Electronically Generated Messages:
(Please Circle Only One Option) Voice Text Portal Messages

If Voice, Please Select Preferred Number
Home Cell Work

Marital Status **(Please Circle Only One Option)** Married Single Divorced Other _____

Date of Birth:	Social Security Number:	Sex: Male Female Transgender
Employer Name:	Emergency Contact Name:	
Emergency Contact Phone #:		Relationship to Patient:

Responsible Party: If the patient is a minor (under the age of 18), the parent or guardian breinging the patient in will be listed as the guarantor:

Last Name:	First Name:	
Date of Birth:	Social Security #	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Additional Information (Please Fill Out All Sections Below):

Email Address:

Race **(Please Circle One)**:
White Americal Indian or Alaska Native Asian
Hispanic Black or African American Native Hawaiian or Pacific Islander
Other Decline

Ethnicity **(Please Circle One)**:
Hispanic or Latino
Not Hispanic of Latino
Decline

Preferred Language **(Please Circle One)**
English Bosnian Indian (Including Hindi & Tamil)
Sign Language Spanish Russian Other

Preferred Pharmacy Name & Location:

	Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name:		Ins. Co. Name:
Policy Holder Name:		Policy Holder Name:
Policy Holder's Date of Birth:		Policy Holder's Date of Birth:
Policy Holder's Social Security #:		Policy Holder's Social Security #:
Patient Relationship to Policy Holder:		Patient Relationship to Policy Holder:

I certify that I have read and agree to AZ Premier Mobile Providers' (APMP) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to APMP all money to which I am entitled for medical expenses related to the services performed from time to time by APMP, but not exceed my indebtedness to APMP. I authorized APMP to release any medical information to my insurance carrier or third party payer to facilitat processing my insurance claims. I understand that failure to pay outstanding abalances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 returned check fee will be charged for check returned due to insufficient funds. I choose to receive communications from APMP by text or e-mail at the number or address stated above, including but not limited to communication about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits by made to APMP. I authorize any holder of medical information about me to release CMS and its aents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Primary Health Medical Group's Privacy Notice. _____ (Initials)

Signature of Responsible Party: X_____ Date: _____

Printed Name of Responsible Party: X_____ Date: _____