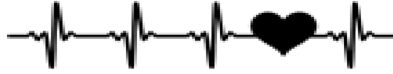
PREMIER CARE MEDICAL SERVICES PLLC

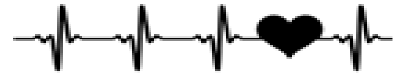


212 W SUPERSTITION BLVD, SUITE 101-1

APACHE JUNCTION, AZ. 85119

OFFICE# (480) 877-0120

FAX# (480)522-3262



DEMOGRAPHIC WORKSHEET

Name: ____ Date of Birth: ___/___/______

Address: ____Zip: _________

Gender: M / F Social Security number: _______-______-_______

Telephone #: _________________________Okay to leave a message on this number: Y / N

Cell #: ______________________________ Okay to leave a message on this number: Y / N

Consent to send information and lab results via email / text / both? Y / N

Work#: _______________________ E-Mail: ____

If Under 18: Mother's / Father's Name: ____

Emergency Contact: __________________ Phone#: ____________ Relationship: __________

Pharmacy with address or cross streets: ____

Who can we share information with: ____

Email: _______________________________________ Phone#: ______________________

INSURANCE:

Primary Insurance: ____________________ Policy# ______________ Group# _________

Policy Holders Name (as it appears on the card): _______________________________________

Policy Holders Date of Birth: ____/____/____ Relationship to Patient: ________________

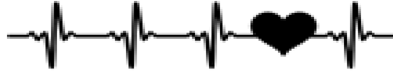
Secondary Insurance: __________________ Policy# _____________ Group# _________

Signature: ____ Date: ____/____/______.

Referred by: ___________________________

REV. 8 JAN 2021

PREMIER CARE MEDICAL SERVICES PLLC

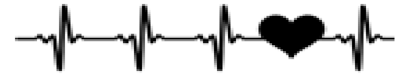


212 W SUPERSTITION BLVD, SUITE 101-1

APACHE JUNCTION, AZ. 85119

OFFICE# (480) 877-0120

FAX# (480)522-3262



1. **DATE OF ONSET OF SYMPTOMS: ___/___/___**
2. **IS THIS YOUR FIRST COVID TEST? Y / N**
3. **COUGH? Y / N ------- DRY / PRODUCTIVE**
4. **Circle all that apply:**
   a. **FEVER, DIZZINESS, NAUSEA, VOMITING, DIARRHEA, (MUSCLE, JOINT, OR BODY ACHES), FATIGUE, HEADACHE, LOSS OF SMELL, LOSS OF TASTE.**

HISTORY

____

____.

MEDICATIONS

____

____.

ALLERGIES

____

____.