Premier Health Care, Inc.
218 Pasadena Avenue South
St. Petersburg, FL 33707
(727) 345-0160 • Fax (727) 345-0100

Personal Information

Last Name **First** **MI** **SSN:** _ _ _ - _ _ - _ _ _ _

Responsible Party: _____ *SSN:* _ _ _ - _ _ - _ _ _ _

Date of Birth: _ _ / _ _ / _ _ _ _ (MM/DD/YYYY) **Age:** **Driver's License:** _____ (State) (Number)

Sex: M F **Marital Status:** Married / Single / Widowed / Divorced / Separated

Primary Address:

Street Name Apt #

City State ZIP

Home Tel: _____

Business Tel: _____

Religion: _____

Alternate Address:

Street Name Apt #

City State ZIP

Alternate / Cell: _____

Email: _____

Occupation: _____

Emergency Contact: _____

Address: _____

Phone Relationship

How Did You Hear about us? Ad / Friend / Relative / Referral / Walk-in / Internet / Yellow Pages

Payment Information

Person responsible for this account: _____ Relationship: _____

Name of Primary Insurer (if any): _____

Subscriber's Name: _____ DOB:* _ _ / _ _ / _ _ _ _ SSN:* _ _ _ - _ _ - _ _ _ _

Subscriber's ID#: _____ Group #: _____ Effective Date: _ _ / _ _ / _ _ _ _

Name of Secondary Insurer (if any): _____

Subscriber's Name: _____ DOB:* _ _ / _ _ / _ _ _ _ SSN:* _ _ _ - _ _ - _ _ _ _

Subscriber's ID#: _____ Group #: _____ Effective Date: _ _ / _ _ / _ _ _ _

*if the subscriber's name is different from the patient

Assignment and Release

I, the undersigned, have coverage with _____ and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

(Signature of Insured/Guardian) (Date)

Medicare Authorization

I request that payment of authorized Medicare benefits be made to me or on my behalf to Dr. _____ for any services furnished me by that person. I authorize any holder of medical information about me to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. IF "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the Insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurances and the deductibles are based upon the charge determination of the Medicare carrier.

(Beneficiary Signature) (Date)