

# Welcome to Premier

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## Patient Information

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex: F M Marital Status: S M D W

Mailing Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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## Primary Insurance

None

Name/Policy Holder \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance Company \_\_\_\_\_ Patient's Relationship to Policy Holder \_\_\_\_\_

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## Secondary Insurance

None

Name/Policy Holder \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance Company \_\_\_\_\_ Patient's Relationship to Policy Holder \_\_\_\_\_

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## Financial Responsible

Same as Patient

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex: F M Marital Status: S M D W

Mailing Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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**If you have been in an accident (auto, work, other), please ask for our Accident Form**

Patient Initials \_\_\_\_\_ Date \_\_\_\_\_