PRIMARY MEDICINE, LLC
PATIENT REGISTRATION FORM

Name: _____ S.S.N:_____

Birth Date:_____ Home Phone: _____Cell Phone:_____

Address: _____City:_____ State: _____

Zip Code: _____ Email: _____ Sex: M / F

CIRCLE: Married Single Widowed Minor Divorced Partnered for ____ years

Employment/ School
Name/ Address: _____

Occupation: _____ Phone: _____
Emergency Contact/ phone: _____

Pharmacy : _____

Person responsible for the account: _____ Relationship: _____
1st Ins. Co: _____ ID: _____ Grp: _____
2nd Ins. Co: _____ ID: _____ Grp: _____

I certify that I, and/ or my dependent(s) have insurance coverage with _____ and assign directly to Primary Medicine, LLC, all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am basically responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Primary Medicine, LLC may use my healthcare information and may disclose such information to insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or 1 year from the date signed below.

Signature: _____ Date: _____
Relationship, if signed by someone other than patient: _____