**PREMIER MEDICAL CLINIC**
4350 N. Atlantic Avenue
Cocoa Beach, FL 32931

**Last Name:** ________________________________________________________________

**First:** ___________________________________________________________________

**MI:** _____________________________________________________________________

**Date of Birth:** _____ /_____/___________

**SSI #** ________________________

**Sex:** ____Male ___Female

**ADDRESS:**________________________________________________________________

**City:** _______________________________________ **State** _______ **Zip** ______________

**Home phone:** ________________________________________________ (OK to leave message: Yes/No)

**Cell Phone:** __________________________________________________ (OK to leave message: Yes/No)

**Email Address:** _______________________________________________ (OK to email: Yes/No)

**Preferred Language:** ___________________________________________

**Ethnicity:**

__Hispanic/ Latino    __Not Hispanic/Latino    ___Declined

**Marital Status:**

__Married    __Single    __Div./Sep    __Widowed    __Partner

**Race:**

___American Indian/ Alaska Native    __Asian    __Black/African American

__White    __Native Hawaiian/Other Pacific Islander    ___Declined

**RESPONSIBLE PARTY INFORMATION (if different from above):**

Last Name: ___________________________ First: _________________________ (MI) ______ Date of Birth ___/___/________

SSI# ______________________ Relationship: __________ Telephone: _____________________

Address: ____________________________________ City: _________________ State: ____ Zip _______

**PHARMACY NAME** ***(Please Specify so meds do not go to wrong pharmacy):***

**______________________________________________________________________________**

**Street: __________________________________________ City: __________________________**

**INSURANCE INFORMATION. Please present INSURANCE CARDS and PHOTO ID to receptionist. Without the proper insurance documentation, your claims can't be filed in a timely manner. Please be advised that it is your responsibility to be aware of the benefits and have all proper documentation, that your medical plan provides you. Including whether we are in your plan's network or not.**

**Primary Insurance:** _____________________________________ Effective Date: ______________

Subscriber Name: _____________________________________ Date of Birth: ________________

ID# _____________________ Group# _________________ Relationship: __________________

**Secondary Insurance:** _______________________________ Effective Date: ________________

Subscriber Name: ______________________________ Date of Birth: ______________________

ID# _____________________ Group# _________________ Relationship: __________________

**IN CASE OF EMERGENCY CONTACT: NAME (Last, First)**

______________________________________________________________________________

Relationship: ____________________________ Telephone #______________________________

**I agree that the information supplied on this form is accurate and up to date to the best of my knowledge. I understand that I am financially responsible for any balance. I hereby authorize any treatment(s) agreed upon with this provider which may be deemed advisable.**

**SIGNATURE: ______________________________________________ DATE ________________**