Premium Medical Care, LLC

Patient Registration

First Name: _____ Last Name: _____ Middle In.:_____

Social Security #: _____ Date of Birth: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone (_____) _____ Cell Phone (_____) _____

Gender: M / F Race: _____ Circle One: Hispanic / Non-Hispanic

Preferred Language: _____ Email Address: _____

Emergency Contact Name: _____ Phone Number: (_____) _____

Employment

Patient's Employer: _____ Patient's Occupation: _____

Employer's Address: _____

Employer's Phone: (_____) _____

Responsible Party

Name: _____ Soc. Sec. #:_____

Address: _____ Phone: (_____) _____

Relationship to Patient: _____ Occupation: _____

Employer: _____ Work Phone: (_____) _____

Work Address: _____

Insurance

Primary Insurance: _____ Secondary Insurance : _____

Soc. Sec. or ID #: _____ Soc. Sec. or ID #: _____

Group or Policy #: _____ Group or Policy #: _____

Policyholder's Name: _____ Policyholder's Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Pharmacy

Name: _____ Phone #: (_____) _____

Address or Intersection: _____

May we check your medication history with your pharmacy? Y / N