

**Premier Community HealthCare Group, Inc.
Patient Registration Form**

Guarantor's Information: (Person responsible for payment) **If patient is a child list both parents below.**

First Name _____ Middle Name _____ Last Name _____

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Employed: Yes No Employer/School Name _____

Home Phone (____) _____ Work Phone(____) _____ Date of Birth _____

Marital Status Single Married Other Email Address _____

Race: Black White Hispanic/White Hispanic/Black Asian American Indian/Alaskan Native
 Native Hawaiian Pacific Islander Haitian Black Haitian Hispanic Haitian/White Other

Patient/Dependent Information: Relationship to Guarantor: Self Child Spouse Other

First Name _____ Middle Name _____ Last Name _____

Date of Birth: _____ Sex: Male Female

Marital Status: Single Married Other Are you a Military Veteran? _____

Race: Black White Hispanic/White Hispanic/Black Asian American Indian/Alaskan Native
 Native Hawaiian Pacific Islander Haitian Black Haitian Hispanic Haitian/White Other

Emergency Contact:

Name: _____ Phone # _____

Name: _____ Phone # _____

Do you have any handicaps we should be aware of? _____

What is your preferred Language? _____ Do you need a Interpreter? _____

About your home, Do you Own/Rent Live with a friend(double up) Apt/House less than 12 months Car

Shelter Transitional House Hotel/Motel Substance Abuse Cnt Other _____

Have you worked in any of the following jobs in the past 2 years? Yes No

Fruit Farm	Dairy Worker	Fish Farm(not tropical)
Food Processor Vegetable Picker	Plant Nursery	Logging
Chicken Farmer Sod Farmer	Fruit/Vegetable Hauler	Grove Work
Commercial Fishing	Other Agriculture Job	Farm Work

(If yes, complete the following)

Does your family stay in the area while you do the work? Yes No

Do you travel away from this area to do this work? Yes No

If you travel away from this does your family travel with you? Yes No

I, _____ give my permission to the PCHG Medical/Dental Providers to treat/prescribe for _____ (myself/child) as medically necessary. A parent, legal guardian or responsible adult with written parental/legal consent, must accompany all children throughout the entire examination. I authorize PCHG to release any information to my insurance company.

Date: _____ Signature: _____