PREMIER HEALTH CENTER
277 PROSPECT AVE SUITE LG
HACKENSACK, NJ 07601

CONFIDENTIAL PATIENT INFORMATION

GENERAL INFORMATION

Name: _____ SSN: _____

Address: _____ Cell Phone: _____

City: _____ Home Phone: _____

State: _____ Zip: _____ Age: _____

Sex: _____ Height: _____ Weight: _____ Birth Date: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

_____

Marital Status: M S W D How many children? _____

Insured name if patient is a dependant: _____

Name of Insurance Company: _____

Policy Holder Name: _____ Relationship to Policy Holder: _____

Policy Holders Address: _____

Policy Holder's Birth Date: _____

Email Address: _____

Name of Husband and/or Wife: _____ Occupation: _____

Patients nearest relative: _____ Phone #: _____

HEALTH INFORMATION

Is your condition work related: □Yes □ No

The date symptoms appeared or accident happened: _____

Date of last physical: _____ Female: Are you pregnant: _____

What operations have you had: _____

Serious illness: _____

_____

HAVE YOU EVER SUFFERED FROM?

□Allergy	□Foot trouble	□Sinus Infection	□Headache
□Dizziness	□Low Back Pain	□High Blood Pressure	□Poor Posture
□Fatigue	□Neck Pain	□Low Blood Pressure	□Poor circulation
□Loss of Sleep	□Sciatica	□Rapid Heart Beat	□Ulcers
□Arthritis	□Asthma	□Difficulty breathing	□Spinal Curvature
□Bursitis	□Ear noises	□Varicose Veins	□Slow heart beat
□Enlarged thyroid	□Kidney infection	□Depression	□Eye pain
□Prostate trouble	□Swollen joints	□Failing vision	□Irregular cycle
□Stroke	□Venereal disease	□Colon trouble	□Tuberculosis
□Diabetes	□Chest pain		

TINGLING AND NUMBNESS IN:

___ Shoulder	____ Hip
___ Arms	____ Legs
___ Elbows	____ knees
___ Hands	____ Feet

HABITS	**HEAVY**	**MODERATE**	**LIGHT**	**NONE**
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____

The purpose of this appointment (major complaint): _____

_____

What activities aggravate your condition _____

_____

Is this condition getting progressively worse? □ Yes □ No □ Constant □ comes and goes

Is this condition interfering with you? □ work □ Daily routine □ Sleep □ other

_____

How long has it been since you really felt good? _____

What do you believe is wrong with you?_____

Other doctor's seen for this condition?_____

Have you been treated for any health conditions by a physician in the last year: □ Yes □ No
Describe _____

What medication or drugs are you taking? _____

Remarks and additional information: _____

_____

Are you insured? □ Yes □ No Insurance Company: _____

Type of Plan: □ HMO □PPO

□POS □EPO

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and my self. Furthermore, I understand that this office will prepare any necessary reports or forms to assist me making collections from the insurance company and than any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered are to be charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient signature: _____ Date: _____

Guardian or Spouse's Authorizing Care _____ Date: _____

Comments: _____

_____

_____

_____

_____

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZATION FORM

Premier Health Center, P.C.

Financial Responsibility

I have requested professional services from Premier Health Center, P.C. ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. Furthermore, the Provider shall have every right and I hereby authorize the Provider to request a Summary Plan Description ("SPD") on my behalf.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient _____ Date _____

Policyholder/Insured _____ Date _____