PREMIERH HEALTH SC

Patient Registration Form

First Name: ________________________ Last Name: ________________________________ MI: __________

Address: ______________________________ City: _____________________ St:_______ Zip: _____________

D.O.B: _____/_____/___ Ethnicity: ________________________ Gender: MALE FEMALE

Home Phone: (____) ______________-______________ Work Phone: (_____) ___________-______________

Marital Status: Single ____ Married _____ Divorced_____ Separated____ Widowed_______

Email Address: ____

Employer Name: _______________________________________ Employer Covered: Yes/NO

Employer Address: __________________________________City: ________________St: ______ Zip: _______

I agree that is my responsibility to get any referrals required by my insurance company for the purpose of this visit(s). I agree that any bills generated from my visit(s) with Dr. Okundaye are my responsibility. All checks returned for insufficient funds will incur an extra charge of $25.00. I understand that I will be personally billed for any unpaid balance after 90 days of service regardless of insurance coverage. I also understand that balances unpaid after 120 days of service will be turned over to a collection agency. I agree to pay all fees incurred during the collection process.

Signature: ____ **DATE:** ___________________________

Guarantor: person responsible for payment of bill, if different than patient name above.

Name: _________________________________ D.O.B.___________________________

Address: ____ City: __________________ St: _____ Zip: _______

Phone: (_____) _____________-__________ Work: (_____) _________-___________ Relation: __________

Person to notify in case of emergency:

Name: ____ Phone: (____) ________-_________ Relation: ____

Address: ________________________________ City: __________________ St: __________ Zip: _________

Name: ____ Phone: (____) _______-_________ Relation: _____

Address: _______________________________________ City: _______________ ST: _______ Zip: __________