PREMIER
MEDICAL INTEGRATION

ENTRANCE APPLICATION

Welcome! We are honored that you chose us to evaluate your condition, and we feel you are in the right place!
In order for us to better serve you, please fill out the form below completely.
If you need any assistance, feel free to ask our staff.

Name: ____ Date: ____________________
First *Middle* *Last*

Address: ______________________________ City: __________________ State: _______ Zip: ____________

Home Phone: _________________________ Cell Phone: ___________________________

Email: ________________________________ How Did You Hear About Us? _________________________

What Is You Primary Complaint? ____

IS THIS WORKMAN'S COMENSATION? Y N **IS THIS AN AUTO ACCIDENT?** Y N

Birth Date: _______________ **Age:**_______ **Sex:** ☐ Male ☐ Female **Height:** _________ **Weight:**_______

Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse's Name: ___________________ # of Children: ________

Social Security # _______-_____ -_______ Driver's License #: ___________________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Unemployed

Occupation: ___________________________ Employer: _______________________ Insurance? Y N

Primary Care Physician: ______________________________ Phone #: _________________________

In case of an emergency, whom should we contact? ___________________________ Relationship: _______________

Cell Phone #: _________________________ Alternate Phone #: _________________________

INSURANCE INFORMATION

Insured Name: ______________________ Insured DOB: __________ Insured SS #: _______-_____ -_______

Group #: ________________ Policy #: _________________ Employer Name: ________________________

Patient Informed Consent

I, ___________________________ the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and those portions of my body may need to be examined. I understand and consent to clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance, and I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature: ____ Date: __________________