PATIENT INFORMATION

Date:_____

FIRST NAME:_____ **LAST NAME:**_____

ADDRESS:_____

CITY/ STATE /ZIP:_____

SOCIAL SECURITY #:_____ **DRIVERS LICENSE #:**_____

EMPLOYER:_____

ADDRESS:_____

CITY/ STATE /ZIP:_____ **E-MAIL:**_____

HOME NUMBER:_____ **WORK NUMBER:**_____

CELL NUMBER:_____ **CELL CARRIER:**_____

Age _____ **Date of Birth** _____ **Marital Status: M S D W**

Emergency Contact:_____ **Phone:**_____

I give permission to Priority Medical Associates to contact myself VIA text messaging and or email regarding my upcoming appointments and possible promotions that they may be offering.
YES NO INITIALS_____

I understand and agree that health, automobile, and other insurance policies are arrangement between an insurance carrier and myself. Furthermore, I understand that Priority Medical Associates or its wholly owned subsidiaries will prepare any necessary reports and forms to assist me in making collection from the responsible insurance company and that any amount authorized to be paid directly to Priority Medical Associates and its wholly owned subsidiaries will be credited to my account on receipt. I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my treatment, all fees for professional services rendered will be immediately due and payable. I was not solicited or persuaded by any person to seek services by Priority Medical Associates.

Patient's Signature: _____ **Date:** _____

Guardian or Spouse's Signature:_____ **Date:**_____