PREMIER
FAMILY MEDICINE - URGENT CARE - WELLNESS

Update of Patient Information

First Name	Middle Name	Last Name	Gender ☐ Male ☐ Female
Street Address	City, State, Zip	E-mail Address *(Required)*	
Date of Birth / /	SSN - -	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widowed	
Preferred Phone	Secondary Phone	May we activate your Patient Portal so you may access your records ☐ Yes ☐ No	
What is your *preferred* method of contact? ☐ Home Phone ☐ Cell Phone ☐ E-Mail ☐ Mail			
Employer ☐ Check here if Retired	Occupation	Referred By	
Emergency Contact	Contact Phone	Relationship to Patient ☐ Spouse ☐ Child ☐ Sibling ☐ Parent ☐ Friend	
Race ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ Pacific Islander ☐ American Indian ☐ Other Race:_____ ☐ Unreported/Refused to Report			
Preferred Language	Ethnicity ☐ Hispanic ☐ Non- Hispanic ☐ Unreported/Refused to Report		
Do you have an Advanced Directive or Living Will? ☐ Yes (Please provide a copy for office records.) ☐ No			
Name Financially Responsible Party	SSN of Insured - -	Date of Birth / /	
Relationship of Financial Party to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian			

Reason for Visit:

What are your Overall Top Health & Wellness Concerns:

1. _____
2. _____
3. _____

MEDICATIONS/SUPPLEMENTS/VITAMINS: ☐ Check here if not on Medications			ALLERGIES: MEDICATION & NON MEDICATION ALLERGIES:
1._____	4._____	7._____	1._____
2._____	5._____	8._____	2._____
3._____	6._____	9.	3._____

SURGERIES: ☐ Check here if no Surgery History	HOSPITALIZATIONS: ☐ Check here if no Hospital History

Patient-Centered Healthcare

_____***(initials)*** Our goal is to be your partner in healthcare and offer you quality and evidence-based care. We value continuity of care and want you to be able to identify one of our providers as your personal healthcare provider. It is our goal to coordinate your healthcare across all of the settings in which you may receive care. In order for us to create a patient-centered-medical home we need you to take an active role in your healthcare. It is your responsibility to provide a complete medical history as well as any information about care you receive outside of our practice. Please keep your provider informed of new medicines, allergies, hospitalizations, specialty visits, test results, and vaccines.

_____(Please list your healthcare provider of choice)

Premier Urgent Care **Premier Family Health & Wellness** **Premier Center for Healthy Aging**