

# Premier Health, S.C.

1540 Lyon Dr. Neenah, WI 54956 ■ Phone: 920-727-4946 ■ Fax: 920-727-4956

## Patient Registration Form

(Please Print)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_

Apt. # \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Marital Status \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed

Employer Name: \_\_\_\_\_ Employer Covered (circle) Y / N

Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

.....  
I agree that it is my responsibility to get any referrals required by my insurance company for the purpose of this visit(s). I agree that I will give 24 hours notice when canceling an appointment, as failure to do so may result in a \$25.00 penalty fee. I agree that any bills generated from my visit(s) with Dr. Okundaye are my responsibility. I understand that I will be personally billed for any unpaid balance after 60 days of service regardless of insurance coverage. I also understand that balances unpaid after 90 days of service will be turned over to a collection agency. I agree to pay all fees incurred during the process.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor: (Person responsible for payment of bill, if different than patient name above)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

D.O.B. \_\_\_/\_\_\_/\_\_\_ Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (work) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relation to you: \_\_\_\_\_

Person to notify in case of emergency:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (work) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relation to you: \_\_\_\_\_

Next of Kin:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (work) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relation to you: \_\_\_\_\_