PREMIER Community HealthCare
YOUR HEALTH. OUR MISSION.

Patient Information Form

First Name: _____ **Last Name:** _____ **Date of Birth:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Physical Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Preferred Phone:** ☐ Home ☐ Mobile ☐ Work

E-mail address: _____

Preferred Method of Appointment Reminders: ☐ Voice ☐ Text ☐ Email ☐ Do Not Contact

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender: ☐ Female ☐ Male

Questions regarding gender and sexual orientation are not required for patients less than 18 years of age.

Collecting gender identity and sexual orientation data is important to help reduce health disparities and promoting culturally competent care in health centers.

Sexual Orientation (a person's sexual identity in relation to the gender to which they are attracted)

☐ Lesbian / Gay ☐ Straight (Not Lesbian / Gay) ☐ Bisexual

☐ Other_____ ☐ Don't know ☐ Choose not to disclose

Gender Identity (a person's perception of having a particular gender, which may or may not correspond to the gender they were at birth.)

☐ Male ☐ Female ☐ Transgender Male (Female-to-Male) ☐ Transgender Female (Male-to-Female)

☐ Other _____ ☐ Choose not to disclose.

Office Use Only

Care Team Member Signature: _____ Date: _____

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Race: ☐ White ☐ Black ☐ American Indian / Native Alaskan ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Asian ☐ More than one race ☐ Decline to answer

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino Preferred Language:_____

Employment Status: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Full Time Student ☐ Part Time Student Employer / School Name:_____

Do you have health insurance? ☐ Yes ☐ No If yes, name of insurer?_____

Emergency Contact: _____ **Relationship:** _____

Phone Number: _____ **Preferred Language:** _____

Parent / Legal Guardian Information: (complete only if patient is a minor)

Mother's Name: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Father's Name: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Guardian's Name: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Phone Number: _____ **Phone Type:** ☐ Home ☐ Mobile ☐ Work

E-mail Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ White ☐ Black ☐ American Indian / Native Alaskan ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Asian ☐ More than one race ☐ Decline to answer

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino Preferred Language:_____

Employment Status: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Full Time Student ☐ Part Time Student Employer / School Name:_____

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Do you have internet access? ☐ Yes ☐ No

Premier participates in the 340B Drug Pricing Program. This program is a U.S. federal government program that requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices.

Premier patients can opt to have prescriptions prescribed by Premier providers filled under this program by using one of the following pharmacies. By doing so, this will allow you to receive a reduced price for qualified prescriptions.

☐ **Walgreens #04811** – 12807 US Hwy 301, Dade City
☐ **Walgreens #05414** – 9220 Little Rd, New Port Richey
☐ **Walgreens #05604** – 6429 Gall Blvd, Zephyrhills
☐ **Walgreens #06412** – 28115 SR 54, Wesley Chapel
☐ **Walgreens #11790** – 36515 SR 54, Zephyrhills
☐ **Walgreens #12318** – 2480 US Hwy 19, Holiday
☐ **Walgreens #0440** – 8951 Hudson Ave, Hudson
☐ **Walgreens #03629** – 12028 Majestic Blvd, Hudson
☐ **Walgreens #03836** – 9332 US Hwy 19, Port Richey
☐ **Walgreens #05857** – 7420 SR 54, New Port Richey
☐ **Walgreens #06886** – Massachusetts Ave, New Port Richey
☐ **Walgreens #07466** – 14217 US Hwy 19, Hudson
☐ **Walgreens #16262** – 105 Mariner Blvd, Spring Hill

Please check a pharmacy above or list the pharmacy preferred: _____

Address: _____ **Phone:** _____

Check your living arrangements: ☐ Own / Rent ☐ Shelter ☐ Homeless ☐ Public Shelter ☐ Street / Car

☐ Living With Friend / Doubling Up ☐ Transitional ☐ Other: _____

In the past two years, or prior to retirement or disability:

- **Have you or the head of your household worked in agriculture?**

  ☐ Yes ☐ No

- **Did you or the head of your household move from this area to another County or State in search of agricultural work?**

  ☐ Yes ☐ No

- **Has your family lived in this area and earned more than half their income from seasonal agriculture?**

  ☐ Yes ☐ No

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Have you served in the U.S. Armed Forces? ☐ Yes ☐ No

Armed Forces Separation Date: _____ ☐ Still Serving

Are you a refugee? ☐ Yes ☐ No Country of Origin: _____

Please circle or check your household size and annual household income range. (*Information for reporting purposes only)*

Household Size	Annual Household Income				
1	$0 - $12,140	$12,141 - $16,146	$16,147 - $20,152	$20,153 - $24,280	$24,281 and up
2	$0 - $16,460	$16,461 - $21,892	$21,893 - $27,324	$27,325 - $32,920	$32,291 and up
3	$0 - $20,780	$20,781 - $27,637	$27,638 - $34,495	$34,496 - $41,560	$41,561 and up
4	$0 - $25,100	$25,101 - $33,383	$33,384 -$41,666	$41,667 - $50,200	$50,201 and up
5	$0 - $29,420	$29,421 - $39,129	$39,130 - $48,837	$48,838 - $58,840	$58,841 and up
6	$0 - $33,740	$33,741 - $44,874	$44,875 - $56,008	$56,009 - $67,480	$67,481 and up
7	$0 - $38,060	$38,061 - $50,620	$50,621 - $63,180	$63,181 - $76,120	$76,121 and up
8	$0 - $42,380	$42,381 - $56,365	$56,366 - $70,351	$70,352 - $84,760	$84,761 and up

Patient's Signature: _____ Date: _____

Parent or Patients Representative's Signature: _____ Date: _____
(if applicable)

Relationship to Patient: _____

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Care Team Member Signature: _____ Date: _____

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1. **Medical Home**
   I choose to participate in the patient centered medical home program. A Patient Centered Medical Home is not a building, house or hospital, but rather an approach to providing total health care. A Medical Home is called a "Home" because we would like this office to be the first place you think of for all your health care needs.

2. **Release of Information**
   Protected health care information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or any other purpose related to benefit payment.

   If I am covered by Medicaid, Medicare or other Health Plan, I authorize the release of protected health care information to the appropriate agency for payment of the claim. The information may include, without limitation, history and physical, emergency records, laboratory reports, drug and alcohol treatment and discharge summary.

   Federal and state laws may permit this facility to participate in organizations with other health care providers, insurers, and/or health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records, decreasing the time needed to access my information, continuity of care; and such other purposes as may be permitted by law. I understand this facility may be a member of such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases such as HIV and AIDS.

   I hereby authorize the practice and the physicians or other health professionals involved in my care to release health care information for purposes of treatment, payment and/or health care operations.

3. **Patient Rights & Responsibilities, HIPAA, Financial Policy & Patient Centered Medical Home**
   These documents are posted in the lobby and on our website: www.premierhc.org. I acknowledge that I have received or have been allowed to view a copy of each and understand and agree to the terms set forth in the policies.

4. **Disclosures to Family Members and or Friends**
   I give permission for my protected health information to be disclosed for purposes of coordination, healthcare needs, communicating results, findings and care decisions to the family members and or friends listed below.

Name	Relationship	Contact Number

5. **Consent for treatment**
   I hereby consent and authorize treatment at Premier Community Healthcare Group inc, (PCHG), for myself, the patient.

Office Use Only

Care Team Member Signature: _____ Date: _____

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Patient Information Form

6. Consent for treatment of a minor

I, as the parent or legal guardian, do hereby give my consent and authorization for treatment of my child _____. Furthermore, I grant permission for the following individuals to authorize Medical/Dental treatment in my absence.

Name	Relationship	Contact Number

7. Notice of Policy Regarding Advanced Directives (for patients over 18 years of age)

Advanced Directives are legal statements that indicate the type of medical treatment desired or not desired in the event an individual is unable to make decisions as well as who is authorized to make them. Advance directives are made and witnessed prior to serious injury or illness.

In accordance with federal and state law, this serves as notification that we will set aside your advanced directives in the event you experience a life-threatening event while at one of the PCHG locations and you will be transferred to a higher level of care, i.e. hospital.

Please indicate below whether you have an advanced directive or if you would like to receive information on advanced directives.

☐ I have an advanced directive.
☐ I do not have an advanced directive.
☐ I would like to receive information on advanced directives.

8. Residents and Students

I understand that Premier Community HealthCare Group, Inc., supports education of medical/dental professionals and maintains residents and students that may assist in relation to your care.

By signing below, I agree, understand and consent to all in this notification.

Patient's Signature: _____ Date: _____

Parent or Patients Representative's Signature: _____ Date: _____
(if applicable)

Relationship to Patient: _____

Office Use Only

Care Team Member Signature: _____ Date: _____