PREMIER WELLNESS INTERNAL MEDICINE, LLC

Michelle Sun, M.D., P.A. **Catheryne Zavodny, M.D., P.A.**

Patient Registration

Name: ____ Age: ________ Birth date: ___________________

Address: _________________________________ City, State: __________________________ Zip: _____________

Home Phone: __________________ Work Phone: ___________________ Mobile Phone: ______________________

SSN: _________________________ Medicare #: _______________________________

Employer: ______________________________________ Occupation: ____________________________________

Bus. Address: _____________________________ City, State: __________________________ Zip: _____________

Driver's License #: __________________ State: ________________ Marital Status: ______________

Referred by: ______________________________________

Insurance Information

Insured's Name: ____ Birth Date: ____________________________

Insured's Employer: _______________________________ Insurance Carrier:________________________________

Group #: __________________ ID #: _________________________________ PPO? Yes _______ No __________

Insurance Company Address: ____

City: __________________________________ State: ____________________ Zip: _____________

Secondary Insurance Information—If None, Check Here: ____

Insured's Name: ____ Birth Date: ____________________________

Insured's Employer: _______________________________ Insurance Carrier:________________________________

Group #: __________________ ID #: _________________________________ PPO? Yes _______ No __________

Insurance Company Address: ____

City: __________________________________ State: ____________________ Zip: _____________

Emergency Contact Information

Name:____________________________ Phone:___________________________ Relationship:_________________