



Premier Diabetes Care, PLLC

6101 123rd Ave SE Unit B, Snohomish, WA 98290
425-318-7144 (800) 516-6570 Fax 949-404-6552

<http://www.premierdiabetescare.com>

New Patient Form

Full Name

First

Middle

Last

Suffix

Sex Male Female

Date of Birth / /

Primary Phone Home Mobile Work

Phone Number

Email

Social Security Number

Address Line 1

Address Line 2

City

State Zip

Marital Status

Maiden Last

Driver's License State

Driver's License #

Demographics

Sexual Orientation

Gender Identity

Hispanic or Latino? Yes No Decline to Specify

Ethnicity

Race

Language

Emergency Contact

Relationship to Contact

Full Name

First

Middle

Last

Primary Phone Home Mobile Work

Phone Number

Email

Address Line 1

Address Line 2

City

State Zip

Financial Information

Responsible Party

Who will be financially responsible for you? Myself Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name _____

First

Middle

Last

Primary Phone Home Mobile Work

Phone Number _____

Method of Payment

What will be your method of payment? Insurance Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company _____

Policy Number _____

Insurance Plan _____

Insurance Phone Number _____

Group Number _____

Insurance Company Address _____

Address Line 2 _____

City _____

State _____

Zip _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name _____

First

Middle

Last

Sex Male Female Unknown

Date of Birth _____ / _____ / _____

Policy ID Number _____

Social Security Number _____

Policy Holder Address _____

Address Line 2 _____

City _____

State _____

Zip _____

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company _____ Policy Number _____

Insurance Plan _____ Insurance Phone Number _____

Group Number _____

Insurance Company Address _____ Address Line 2 _____

City _____ State _____ Zip _____

Relationship to Secondary Policy Holder _____

If you are not the secondary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex Male Female Unknown Date of Birth ____/____/____

Insurance ID Number _____ Social Security Number _____

Policy Holder Address _____ Address Line 2 _____

City _____ State _____ Zip _____

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us? _____