PREMIER MEDICAL CARE

Unit 14A Rankin's Plaza • Eastern Avenue
P.O. Box 1059 Grand Cayman KY1-1102 • CAYMAN ISLANDS
Phone: (345) 945-2273 • Fax: (345) 945-8553 • Cell: (345) 925-5777

Please complete this form as accurately as possible, and return to receptionist upon completion.
If you require help to do this, we will be more than happy to assist you. All information is strictly confidential.

Full name: _____
First Name Middle Name Last Name

If under the age of 16, please give contact details of Parent/Guardian: _____

Date of Birth: _____ **Mother's Maiden Name:** _____
MM/DD/YYYY

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced

Country of Birth: _____ Nationality: _____

Mailing Address: _____ Residential Address: _____

Email Address: _____ Cell #: _____

Employer's Name: _____ Work #: _____

Emergency Contact: _____ Phone #: _____

Relationship to Emergency Contact: _____

Insurance Details: ☐ **Not Insured** ☐ **Insured**

Insurance Company: _____ Member ID: _____

☐ I confirm that the information I have provided above, to the best of my knowledge is true and correct.

Do you have any medical conditions?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No
Are you currently taking any medication?	☐ Yes	☐ No
Do you have any allergies or drug allergies?	☐ Yes	☐ No

Does your immediate family ie parents, siblings and/or children have any medical condition(s)? ☐ Yes ☐ No

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Patient Consent Form

I _____ consent to Premier Medical Care that all the above information is correct. I further consent and authorize my physician, his/her assistants and Premier Medical Care staff to perform any examination, diagnostic investigations, care and treatment as deemed necessary. I understand that at any given time I can refuse to undergo any procedure or accept any type of treatment.

I also agree that a copy of my medical records can be provided to my physician or designated referral physician upon request. I hereby authorize Premier Medical Care to release any information requested by my insurance company with the respect to any claim made pursuant to this authorization.

I assume full responsibility for all healthcare charges not covered by any agency/payer for any additional costs that are not entirely covered by my insurance plan.

My signature below verifies that I am now a patient of Premier Medical Care and that I have given correct information to the questions asked.

_____ _____

Signature of Patient/Guardian | Relationship to Patient

_____ _____

Witness | Date Signed