



PATIENT INFORMATION

DATE _____ PHARMACY _____ # _____

GUARANTOR NAME _____ SEX _____ DOB _____

ADDRESS _____ HOME PHONE _____

CITY - STATE _____ ZIP _____ SOCIAL SECURITY # _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

EMERGENCY CONTACT(S): _____ PHONE _____

_____ PHONE _____

PATIENT(S):

CHILD NAME _____ SEX _____ DOB _____ SS # _____

CHILD NAME _____ SEX _____ DOB _____ SS # _____

CHILD NAME _____ SEX _____ DOB _____ SS # _____

CHILD NAME _____ SEX _____ DOB _____ SS # _____

CHILD NAME _____ SEX _____ DOB _____ SS # _____

ADDRESS (if different from Guarantor) _____

INSURANCE INFORMATION:

PRIMARY INSURER _____ PLAN _____ ID# _____ CO-PAY\$ _____

SECONDARY INSURER _____ PLAN _____ ID# _____ CO-PAY\$ _____

OTHER INSURANCE _____ PLAN _____ ID# _____ CO-PAY\$ _____

SUBSCRIBER NAME: _____ SS# _____ DOB _____

EMPLOYER NAME, ADDRESS & # _____

ONE OF THE BELOW MUST BE CHECKED BEFORE VISIT:

I WILL BE PAYING TODAY BY: CASH CHECK CREDIT CARD

SIGNATURE ON FILE

PLEASE READ CAREFULLY AND SIGN:

I request that payment of authorized benefits be made either to me or on my behalf to Alliance Medical Group, Inc. for any services furnished to me by that physician / supplier. I authorize any holder of medical information about me to release to CMS and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits for related services.

I understand that regardless of any insurance coverage I may have, it is my responsibility to pay my bill. I further understand that my insurance is designed to reimburse Alliance Medical Group, Inc. for covered expenses. I understand further that not all services are covered by Medicare or other insurance plans and acknowledge that I am responsible and will pay for those services. I agree to pay all costs of collection, including a reasonable attorney's fee, incurred in the collection of any amounts not paid, as required above.

PATIENT OR RESPONSIBLE PARTY