PATIENT INFORMATION

DATE ______________________ PHARMACY ______________________________________

PATIENT NAME _____________________________ SEX________ AGE_______ DATE OF BIRTH _____________

ADDRESS ___________________________________ HOME PHONE_____________________________________

CITY – STATE ________________________________ ZIP ___________ SOCIAL SECURITY #_________________

EMPLOYER NAME & ADDRESS ____

OCCUPATION ________________________________ BUSINESS PHONE __________________________________

E-MAIL ADDRESS____

HOW WERE YOU REFERRED TO OUR OFFICE?____
WHOM MAY WE CONTACT IN CASE OF EMERGENCY:______________________ PHONE______________

IF THE PATIENT IS A MINOR OR STUDENT:

RESPONSIBLE PARTY_________________________ HOME PHONE______________________________________
ADDRESS____________________________________ BUSINESS PHONE__________________________________

INSURANCE INFORMATION:
PRIMARY INSURER_________________________ PLAN_________ ID#_______________ CO-PAY$_________
SECONDARY INSURER______________________ PLAN_________ ID#_______________ CO-PAY$_________
SUBSCRIBER
NAME:_________________________________ SS#________________ DOB______________________________
EMPLOYER NAME, ADDRESS & #____
RELATIONSHIP TO PATIENT:____

IS THIS VISIT DUE TO A WORK RELATED INJURY? ☐ YES ☐ NO
COMP. CARRIER NAME____

ARE YOU SEEING THE DOCTOR BECAUSE OF AN ACCIDENT? ☐ YES ☐ NO

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 that 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.

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PATIENT OR RESPONSIBLE PARTY