PATIENT INFORMATION

DATE _____ PHARMACY_____PCP_____

PATIENT NAME _____SEX_____AGE_____DATE OF BIRTH _____

ADDRESS _____HOME PHONE_____

CITY – STATE _____ZIP_____-_____

PATIENT'S EMPLOYER NAME & ADDRESS _____

OCCUPATION _____BUSINESS PHONE _____

E-MAIL ADDRESS_____MOBILE PHONE_____

RACE_____ETHNICITY_____PRIMARY LANGUAGE_____MARITAL STATUS: _____

HOW WERE YOU REFERRED TO OUR OFFICE?_____
WHOM MAY WE CONTACT IN CASE OF EMERGENCY:_____PHONE_____RELATIONSHIP:_____

IF THE PATIENT IS A MINOR OR STUDENT:

RESPONSIBLE PARTY_____HOME PHONE_____MOBILE PHONE_____
ADDRESS_____BUSINESS PHONE_____

INSURANCE INFORMATION:
PRIMARY INSURANCE CO_____ PLAN_____ID#_____CO-PAY$_____

SECONDARY INSURANCE CO_____ PLAN_____ID#_____CO-PAY$_____

SUBSCRIBER (INSURANCE HOLDER'S) NAME:_____DOB_____
INSURED'S EMPLOYER NAME, ADDRESS & #_____
CITY-STATE _____ZIP_____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 ☐ 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.

_____
PATIENT OR RESPONSIBLE PARTY