Alliance Medical Group
Waterbury HEALTH

PATIENT INFORMATION FORM

Today's Date: _____
PCP: _____

Pharmacy (Include Address & Phone Number):_____

Demographic Information *(Please Print Clearly)*				
❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Last Name:			Marital Status: *(circle one)* Single / Mar / Div / Sep / Wid
	First Name:	Middle Initial:		
Is this your legal name? ❑ Yes ❑ No	Former Name:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Email Address:				
Street Address/City/Zip Code:				
Home phone: ( )	Cell phone: ( )		Work phone: ( )	

Job Title: _____

Employer Name and Address: _____

Employer phone No.: ( ) _____

EMERGENCY CONTACT: Name: _____ Relationship: _____

Phone(s): _____

How Were You Referred to Our Office? _____

Insurance Information				
Primary Insurance Co.	_____	ID# _____	Group# _____	Co-Pay $_____
Secondary Insurance Co.	_____	ID# _____	Group# _____	Co-Pay $_____

Subscriber (Insurance Holder's Name): _____DOB: _____

Insured's Employer Name, Address, & Phone Number:_____

City/State: _____ Zip Code: _____ Relationship to Patient: _____

Is this visit due to a work-related injury? ❑Yes ❑No

Workers Compensation Carrier Name: _____

Are you seeing the doctor because of an accident? ❑Yes ❑No

Census Information		
RACE	**Primary Race**	**Non-primary Race**
American Indian or Alaskan Native	❑	❑
Asian	❑	❑
Black or African American	❑	❑
Native Hawaiian or Other Pacific Islander	❑	❑
White	❑	❑
Other	❑	❑
Decline to answer	❑	❑
ETHNICITY: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Other ❑ Decline to answer	**PREFERRED LANGUAGE**:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physicians of Alliance Medical Group ("AMG"). I understand that I am financially responsible for any balance, including my policy deductibles and co-insurances. These are required payments by my insurance company, not AMG. I authorize AMG or my insurance company to release any information required to process my claims.

_____ _____ _____
Patient Print Name *Patient Signature* *Date*

_____ _____ _____
Legal Representative/Guardian Print Name *Legal Representative/Guardian Signature* *Date*