ALLIED MEDICAL ASSOCIATES

REGISTRATION FORM

(Please Print)

Today's Date:	FOR OFFICE USE - PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	◯ Mr. ◯ Mrs.	◯ Miss ◯ Ms.	Marital status: Single ◯ Mar ◯ Div ◯ Sep ◯ Wid ◯

Birth date:	Age:	Sex: ◯ M ◯ F	Home phone no.: ( )
Street address:		Social Security no.:	Cell phone no.: ( )

E-Mail Address	City:	State:	ZIP Code:
Occupation:	Employer:		Employer phone no.: ( )

Referred by (Please check one box):	◯ Dr.	◯ Insurance plan	◯ Hospital

◯ Family ◯ Friend ◯ Close to home/work ◯ Yellow Pages ◯ Other

Primary Language: Translator Required? ◯ Yes ◯ No	◯ Hispanic/ Latino ◯ Black or African American ◯ White/Caucasian ◯ Asian ◯ Native American or Alaska Native ◯ Pacific Islander ◯ Other (specify):

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Carrier:	Policy Number:	Group Number:	Policy Holder Name:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:			Co-payment: $

Patient's relationship to subscriber:	◯ Self	☐ Spouse	◯ Child	◯ Other

Name of secondary insurance (if any):	Policy Number:	Group Number:	Policy Holder Name:

Patient's relationship to subscriber:	◯ Self	◯ Spouse	◯ Child	◯ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

I HERE BY AUTHORIZE, ALLIED MEDICAL ASSOIATES TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE CARRIER. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY PAYMENT AT THE TIME OF THE VISIT. I UNDERSTAND THAT THE FEES SET BY THIS OFFICE MAY EXCEED WHAT MY INSURANCE CARRIER CONSIDERS TO BE REASONABLE AND CUSTOMARY CHARGES FOR THIS AREA. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL REGARDLESS OF THE DECISION MADE BY MY INSURANCE CARRIER.

I have read the above information, understand it completely and agree to its terms.

Print Name *Patient/Guardian signature* *Date*