



## REGISTRATION FORM

(Please Print)

Today's Date:			FOR OFFICE USE - PCP:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>
Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Primary Language:		Translator Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Black or African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaska Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> 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:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if any):		Policy Number:		Group Number:	Policy Holder Name:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY				
Name:		Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )
<p>I HEREBY AUTHORIZE, ALLIED MEDICAL ASSOCIATES 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.</p> <p>I have read the above information, understand it completely and agree to its terms.</p>				
<i>Print Name</i>		<i>Patient/Guardian signature</i>		<i>Date</i>