 Alliance Family Physicians, PA 

NEW PATIENT REGISTRATION FORM

DATE: DOCTOR:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | |
| Last Name First Middle | | | | | | | | | | | | Mr. Miss  Mrs. Ms. | | | | | | Marital Status: (circle one)  Sgl. Mar. Div. Sep. Wid. | | | | | |
| Is this your legal Name?  Yes No | If not, what is your legal name? | | | (Former/Maiden Name): | | | | | | | | | | Birth Date: | | | | | | | Age: | | Sex:  M F |
| Race: (Mark One) White African American Asian Other  American Indian Hispanic Choose not to Disclose | | | | | | | | | | Ethnicity: Hispanic or Latino  Non Hispanic or Non Latino Choose not to Disclose | | | | | | | | | | | | | |
| Physical Address City State/Zip Code | | | | | | | | Social Security Number | | | | | | | | Home Phone:  Cell Phone: | | | | | | | |
| Mailing Address (if different from above) | | | | | | | | | | | Email Address | | | | | | | | | | | | |
| Employer Name & Address | | | | | | | | | | | Employer Phone Number | | | | | | | | | | | | |
| Please indicate below who referred you to us and**/**or how you heard about our practice. Please be as specific as possible.  Doctor / Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Member / Friend\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Close to home/work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Advertising: TV/Radio/Newspaper/Magazine or Yellow Pages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| **PREFERRED LANGUAGE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Choose not to Disclose** | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have family members that are seen here? Yes No \*If yes, please list name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| **INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)** | | | | | | | | | | | | | | | | | | | | | | | |
| Subscribers Name | | | Birth Date | | Social Security | | | | | | | | | | | Relationship to subscriber | | | | | | | |
| Address (if different) City State/Zip | | | | | | | | | Home Phone | | | | | | | | | | Cell Phone | | | | |
| Subscribers Occupation | | Employer Name & Address | | | | | | | | | | | | | | | Employer Phone Number | | | | | | |
| Primary Insurance Co. | | | Claims Address (back of card) | | | | Phone | | | | | | | | ID # :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Secondary Insurance Co. | | | Claims Address (Back of card) | | | | Phone | | | | | | | | ID # :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group # :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Are you being seen today as the result of a work related injury? YES NO Automobile Accident? YES NO** | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of injury?\_\_\_\_\_\_\_\_\_\_\_\_\_ Who is your adjuster?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim number assigned \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of your Workers Compensation or Auto Insurance** | | | | **Billing Address** | | | | | | | | | | | | | | | | **Phone** | | | |
| **PRIVACY ACKNOWLEDGEMENT: I have been presented with a copy of this provider’s Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal law. I understand the contents of the notice and by my signature below I agree to the disclosures named in the notice.** | | | | | | | | | | | | | | | | | | | | | | | |
| **To whom may we share your medical information with?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | |
| **For security reasons, please list a unique identifier (code word) that only you and this person will know. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **May we leave lab/x-ray or other medical information on your answering machine or voice mail? YES NO** | | | | | | | | | | | | | | | | | | | | | | | |
| **IN CASE OF EMERGENCY** | | | | | | | | | | | | | | | | | | | | | | | |
| Name & Address of local friend or relative (not living with you) | | | | | | Relationship | | | | | | | Home Phone | | | | | | | | | Work/Cell Phone | |

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I

understand that I am financially responsible for any balance. I also authorize ALLIANCE FAMILY PHYSICIANS or insurance

company to release any information required to process my claims.

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT/GUARDIAN SIGNATURE DATE**