 Alliance Family Physicians, PA 

 NEW PATIENT REGISTRATION FORM

DATE: DOCTOR:

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| **PATIENT INFORMATION** |
| Last Name First Middle | Mr. MissMrs. 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.

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 **PATIENT/GUARDIAN SIGNATURE DATE**