**ALPHA MEDICAL CENTRE**

PATIENT REGISTRATION FORM

DATE _________________________ REFERRED BY_________________________________________________

PATIENT'S NAME ________________________________________________ AGE______ BIRTH DATE_____________________

ADDRESS_______________________________________ CITY _______________________ STATE _____ ZIP CODE________

PHONE NO:____________________________________________ E-mail________________________________________________

MARITAL STATUS: S_____ M_____ D_____ W_____ SEX: M_____ F_____

EMPLOYER_______________________________________________________PHONE NO:_________________________________

ADDRESS____________________________________________CITY_____________________STATE_____ZIP______________

NAME OF SPOUSE/SIGNIFICANT OTHER OR PARENT/GAURDIAN ____________________________________________

ADDRESS IF DIFFERENT FROM PATIENT'S___________________________________________________________

PERSON RESPONSIBLE FOR BILL ________________________________________ RELATIONSHIP________________________

SPOUSE'S OR PARENT'S EMPLOYER_________________________________________________________________

BUSINESS PHONE NUMBER_____________________ OCCUPATION OF SPOUSE/PARENT______________________________

NAME, ADDRESS, PHONE NUMBER AND RELATIONSHIP OF A PERSON NOT LIVING IN YOUR HOME THAT MAY BE CONTACTED IN CASE OF EMERGENCY__________________________________________________________

**IF PATIENT HAS INSURANCE, COMPLETE THIS SECTION**

**INSURANCE CARRIER #1** NAME____________________________________________________________________

ADDRESS_______________________________________________________________________________________

POLICYHOLDER’S NAME____________________________________________ RELATIONSHIP__________________________

POLICY NO.___________________________________________GROUP NO.__________________________________________

**INSURANCE CARRIER #2** NAME____________________________________________________________________

ADDRESS_______________________________________________________________________________________

POLICYHOLDER’S NAME____________________________________________ RELATIONSHIP__________________________

POLICY NO.___________________________________________GROUP NO.__________________________________________

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize Alpha Medical Centre to be my attending physician to administer to me any examination, treatment, and medications deemed necessary to my present complaint. I am aware of and agree to office policy that payment is to be rendered at time of treatment unless other arrangements are specifically made and that cancellation of an appointment must be made 48 hours in advance of the appointment.

I request that payment of authorized Insurance Company benefits be made on my behalf to Alpha Medical Centre for any services provided to me by that party who accepts assignment of benefits.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If my insurance is through another family member, my signature authorizes releasing of the information to the insurer or agency shown as necessary for the processing of the claim through my insurance company.

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Signature of Patient (or Parent if Minor) Date