# **PATIENT INFORMATION FORM**

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PCP:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital Preference:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy (Include Address & Phone Number):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Demographic Information *(Please Print Clearly)*** | | | | | | | |
| * Mr. * Mrs. * Miss * Ms. | Last Name: | | | | | **Marital Status**: *(circle one)*  Single / Mar / Div / Sep / Wid  **Sexual Orientation**:  Lesbian Gay Heterosexual  Bisexual Decline Unknown  Other | |
| First Name: | | Middle Initial: | | |
| Is this your legal name?   * Yes No | Former Name: | | Birth date:  / / | | Age: | **Birth Sex:**  M F  **Gender Identity**:  Male Female Female to Male/Transgender Male  Male to Female/Transgender Female Genderqueer Other  Decline | |
| Email Address: | | | | | | | |
| Street Address/City/Zip Code: | | | | | | | |
| Home phone: ( ) Cell phone: ( ) Work phone: ( ) | | | | | | | |
| EMERGENCY CONTACT: Name: Relationship: Phone(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How Were You Referred to Our Office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Insurance Information** | | | | | | | |
| Primary Insurance Co. | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Group# \_\_\_\_\_\_\_\_\_\_\_\_ | | Co-Pay $\_\_\_\_\_\_\_\_\_\_\_ |
| Secondary Insurance Co. | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Group# \_\_\_\_\_\_\_\_\_\_\_\_ | | Co-Pay $\_\_\_\_\_\_\_\_\_\_\_ |
|  | |  | |  |  | |  |
| Subscriber (Insurance Holder’s Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Insured’s Employer Name, Address, & Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Is this visit due to a work-related injury? Yes No  Workers Compensation Carrier Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you seeing the doctor because of an accident? Yes No | | | | | | | |
| **Census Information** | | | | | | | |
| **RACE** | | | | | **Primary Race** | | **Non-primary**  **Race** |
| American Indian or Alaskan Native | | | | |  | |  |
| Asian | | | | |  | |  |
| Black or African American | | | | |  | |  |
| Native Hawaiian or Other Pacific Islander | | | | |  | |  |
| White | | | | |  | |  |
| Other | | | | |  | |  |
| Decline to answer | | | | |  | |  |
| **ETHNICITY**: Hispanic/Latino Not Hispanic/Latino Other Decline to answer | | | | | **PREFERRED LANGUAGE**: | | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physicians of Alliance Medical Group (“AMG”). I understand that I am financially responsible for any balance, including my policy deductibles and co-insurances. These are required payments by my insurance company, not AMG. I authorize AMG or my insurance company to release any information required to process my claims.

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*Patient Print Name Patient Signature Date*

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*Legal Representative/Guardian Print Name Legal Representative/Guardian Signature Date*