# **PATIENT INFORMATION FORM**

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

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

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

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

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| **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 NoWorkers 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*