

Alleghenies Independent Physicians

Patient Registration Form

Office: _____

Patient Information

Name: _____ Birthdate: ____ - ____ - ____ SS# ____ - ____ - ____
Address: _____ Sex: M or F Age: _____
City: _____ State: _____ Zip: _____ Marital Status: S M D Other
Home Phone: () _____ Work Phone: () _____
Emergency Contact: _____ Relationship: _____ Phone #: () _____
Emergency Contact 2: _____ Relationship: _____ Phone #: () _____
Primary Care Physician: _____ How did you hear about us? _____

Person Responsible for bill (Self if over 18, legal guardian if under age 18)

Name: _____ Birthdate: ____ - ____ - ____ SS# ____ - ____ - ____
Address: _____ Sex: M or F Age: _____
City: _____ State: _____ Zip: _____
Home Phone: () _____ Work Phone: () _____
Employer Name: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance (Please present card for verification)

Insurance Name: _____ Copay Amount – PCP: \$ _____ Specialty: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Sex: M or F Birthdate: ____ - ____ - ____
Insurance ID# _____ Group # _____ Effective Date: ____ - ____ - ____
SS# ____ - ____ - ____ Relationship to Patient: _____ Employer: _____

Secondary Insurance (Please present card for verification)

Insurance Name : _____ Copay Amount – PCP \$ _____ Specialty: \$ _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Sex M or F Birthdate: ____ - ____ - ____
Insurance ID# _____ Group# _____ Effective Date: ____ - ____ - ____
SS# ____ - ____ - ____ Relationship to Patient: _____ Employer : _____

Please Read and Sign Below

Direct Payment Request and Authorization to Release Medical Information

“I hereby authorize the release of information acquired during the course of my examination and treatment to the Health Care Financing Administration and its’ agents, or any other third party carrier as necessary to secure payment of any benefits due to me. I hereby assign payment of said benefits to include Medicare benefits directly to my physician. I understand that I am responsible for all charges regardless of insurance status, as well as any associated costs for collection should such action become necessary. I agree that this authorization shall be valid until canceled in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.”

Patient

Date

Responsible Party

Date