Allied Healthcare
ASSOCIATES

REGISTRATION FORM

Today's Date:		**Email Address:**		
PATIENT INFORMATION				
Last name:	**First:**	**Middle:**	**Marital status:**	
Is this your legal name? ○ Yes ○ No	**If not, what is your legal name?**	**Birth date:**	**Age:**	**Sex:** ○ M ○ F
Address:				
Social Security number:	**Home phone number:**	**Cell phone number:**		
Occupation:	**Employer:**	**Employer phone number:**		
Referred to clinic by: ○ **Doctor** ○ **Other (Please specify)**				
Preferred Pharmacy:	**Pharmacy Location:**			
INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Person responsible for bill:	**Birth date:**	**Address (if different):**	**Home phone no.:**	
Is this person a patient here? ○ Yes ○ No		**Is this patient covered by insurance?** ○ Yes ○ No		
Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:**	
Please indicate primary insurance:				
Subscriber's name:	**Subscriber's S.S. number:**	**Birth date:**	**Group no:**	**Policy no:**	**Co-payment:** $
Patient's relationship to subscriber:				
Name of secondary insurance (if applicable):	**Subscriber's name:**	**Group no:**	**Policy no:**	
IN CASE OF EMERGENCY				
Name of local friend or relative:	**Relationship to patient:**	**Home phone no:**	**Work phone no:**	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

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Patient/Guardian signature **Date**