ALLIANCE CLINICAL
ASSOCIATES

Registration Information (Please Print)

Date: _____ Home Phone : _____ Cell Phone: _____ Wrk Phone: _____

Patient_____
Last Name (**Must be Legal Name)** First Name Middle Initial

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: M ☐ F ☐ Age: _____ Date of Birth: _____ Social Security #_____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Primary Care Doctor_____

Employment: Full time ☐ Part time ☐ Self employed ☐ Retired ☐ Not employed ☐ Student ☐

Email address_____

Whom may we thank for referring you? _____

Emergency Contact? _____ Phone: _____ Relationship:_____

Reason for Visit: _____

Preferred Pharmacy: _____ City _____ Phone #: _____

Known Medical Problems : _____

Allergies: _____

Church or Religious Affiliation: _____

Signature of Patient: _____

(If patient is under age 18) I consent for my minor child to be treated at Alliance Clinical Associates:

Signature of Parent: _____

Signature of Parent #2 (if required by divorce decree) _____

Do you have Medical Insurance? No ☐ Yes ☐ Medicare ☐ 2nd Insurance _____

Primary Insurance Information of Policy Holder

Insurance Company: _____ Phone _____
Address: _____ Policy #_____ Group #_____
Policy Holder Name_____ Soc. Sec. # _____
Date of Birth_____ Employer _____
Employer Address_____ Employer Phone _____

Secondary Insurance Information of Policy Holder

Insurance Company: _____ Phone _____
Address: _____ Policy #_____ Group #_____
Policy Holder Name_____ Soc. Sec. # _____
Date of Birth_____ Employer _____
Employer Address_____ Employer Phone _____