Alliance Medical Associates, PLLC
2905 Crouse Lane
Burlington, NC 27215

Phone: (336) 538-2494
Fax: (336) 538-2497

REGISTRATION

Today's date:	PCP:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former Name):	Birth Date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street Address:	Social Security #:	Home Phone #:
	- -	( ) -

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone #:
		( ) -

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	

Other family members seen here:	

(Please give insurance card to the receptionist) INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home #:
	/ /		( ) -

Is this person a patient here?	❑ Yes	❑ No		Cell # :( ) -

Occupation:	Employer:	Employer address:	Employer #:
			( ) -

Is this patient covered by insurance?	❑ Yes	❑ No	

Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ BCBS	❑ Medcost	❑ Tricare

❑ Aetna	❑ Cigna	❑ Wellpath	❑ United Healthcare	❑ Other	

Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group #:	Policy #:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

PATIENT CARE

Do you have a living will or Power of Attorney for health care decisions? ❑ Yes ❑ No

Do you have a moral or religious reason for refusing a blood transfusion? ❑ Yes ❑ No
If **YES, do you have or need an informed refusal form? ❑ Yes ❑ No*

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:
		( ) -	( ) -

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 Alliance Medical Associates, PLLC or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*