ALLAM MEDICAL GROUP, LLC
PATIENT REGISTRATION

REFERRED BY: _____

Please Print

PATIENT INFORMATION:

NAME: _____ SEX _____ BIRTHDATE: _____

ADDRESS: _____ APT # _____

CITY/STATE: _____ ZIP: _____

PHONE: HOME _____ WORK _____

EMAIL:_____ CELL_____

SS# _____ OCCUPATION: _____

EMPLOYER NAME: _____ EMPLOYER ADDRESS: _____

PREFERRED CONTACT FOR APPOINTMENT CONFIRMATION: CELL OR PHONE VOICE OR TEXT MESSAGE

EMERGENCY CONTACT:

NAME: _____ RELATION: _____

PHONE _____CELL_____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PHARMACY: NAME: _____ PHONE: _____

ADDRESS: _____

INSURANCE INFORMATION: (copy of cards required for billing)

PRIMARY INSURANCE: _____ ID# _____

GROUP # _____ PHONE # _____

ADDRESS: _____

SECONDARY INSURANCE: _____ ID # _____

GROUP # _____ PHONE # _____

ADDRESS: _____

POLICY HOLDER INFORMATION (If different from patient information)

NAME: _____ SEX: _____ BIRTHDATE _____ RELATION _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

SS# _____ HOME PHONE: _____ WORK PHONE: _____

EMPLOYER NAME & ADDRESS: _____

_____

See Back

OFFICE POLICY (of Allam Medical Group, LLC):

It is the policy of this practice that the fees or co-payments are due and payable at the time of each visit. By signing below you agree to be financially responsible for all bills incurred while receiving care at Allam Medical Group, LLC. As a courtesy, insurance billing is provided for all plans in which the physician is a participating member. By signing below you agree that all insurance payments be made directly to ALLAM MEDICAL GROUP, LLC. It is the patient's responsibility to provide his/her insurance card at each visit and to notify us of all changes in coverage.

SIGNED: _____ DATE: _____

ASSSIGNMENT OF BENEFITS:

I authorize payment of medical benefits to Allam Medical Group, LLC for services described. I accept full responsibility for the total amount of the bill. I authorize Allam Medical Group, LLC to file insurance claims on my behalf for services rendered to me.

SIGNED: _____ DATE: _____

MEDICARE ASSIGNMENT:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or their intermediaries or carriers and information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

SIGNED: _____ DATE: _____

RELEASE OF CONFIDENTIAL INFORMATION

I, _____, am aware that Allam Medical Group, LLC, holds my medical information as confidential. My medical care and test results cannot be disclosed or discussed with anyone but myself. I understand this policy and by my signature below I agree to allow the AMG doctors and staff to communicate with the people I have listed below. I will not hold Allam Medical Group, LLC responsible for any confidential information released to the people I have listed below. This permission will stand until changed by myself. I understand that it is my responsibility to forward any changes in writing, if desire to change this release, and that verbal changes may not be honored.

Allam Medical Group, LLC may leave information on my answering machine or voice mail.

HOME: Yes _____ No _____ **Work:** _____ No _____

My medical condition maybe discussed with:

NAME	Phone#	Relationship

I understand this information will stay in my permanent medical record until I give written notice otherwise.

_____ _____

Name (printed) Signature

_____

Date