Alliance Integrative Medicine

Today's Date: ________________

PATIENT INFORMATION (Please Print)

Full Legal Name: ____________________________________ Nickname/Preferred Name:_____________________

Date of Birth: ____/____/______ *(mm/dd/yyyy)* Marital Status: ____ Sex: ____

Street Address: __________________________________City: __________________ State: ___________Zip: ________

Email Address: ____

Home Telephone: ( ) ___________________ Mobile Phone: ( ) ___________________

Employer (Patient only): ________________________________ Work Phone #: ( ) ______________________

Employer Address: __________________________________ City: __________________ State: ______ Zip:_________

Pharmacy Name: ________________________________ Telephone #: ( ) _________________________

GUARANTOR INFORMATION (Complete if you ARE NOT the SUBSCRIBER)

Name: Full Legal Name: ____

Social Security #: _____________________________ Date of Birth: _____/_____/_______ *(mm/dd/yyyy)*

Street Address: ____

City: _____________________________ State: _________ Zip: ____________

Home Phone #: ( ) ___________________ Mobile Phone #: ( ) ___________________

Employer _______________________________ Work Phone # ( ) _____________________

Employer Address: ________________________________ City: ____________________ State: ____ Zip:_______

With whom may we share your information:

□ Your referring MD/DO:___________________________

□ Other :____ Relationship _______________________________

□ Other:____ Relationship _______________________________

□ Other:____ Relationship _______________________________

____ ____

Patient/Guardian Signature Today's date

INSURANCE INFORMATION

Primary Insurance: ___________________________ Secondary Insurance: ___________________________________

Member ID # ________________________________ Member ID # ____________________________________

Group ID # __________________________________ Group ID # ______________________________________

We'd like to know…Where did you hear about us?

___Physician Referral (Name of Referring Physician) :_________________________) ____ Website ____Advertisement

___Personal Referral (May we ask whom: ___________________________________) ____ Other: ______________________

Rev.
3/18