ALAMO
Family Practice

REGISTRATION INFORMATION

Patient Information

Name_____ Sex_____ Date of Birth_____ Marital status_____

Address_____ City_____ State____ Zip_____

Phone # _____

SSN_____ Driver's License #_____

Employer_____ Employer's address_____

Employer's Phone # _____

Preferred Pharmacy Name/Location/Phone_____

Responsible Party

Name_____ Date of Birth_____ Relation_____

Address_____ City_____ State____ Zip_____

SSN_____ Driver's License #_____

Employer_____ Employer's address_____

Employer's Phone # _____

Emergency Contact

Name_____ Relationship_____ Phone _____

Address _____ City_____ State____ Zip_____

I hereby authorize Alamo Family Practice to release any pertinent medical information which may include conditions concerning mental health, alcohol and/or drug abuse, that is necessary for the processing of claims to my medical insurance, and request assignment of insurance benefits either to myself **or an my behalf to Alamo Family Practice.** I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for all charges whether or not covered by insurance.

Authorized signature_____ Date _____