Insurance Registration

Patient Name: _____
Sex: M or F Date of Birth: _____ SSN : _____
Address:_____
City: _____ State: _____ Zip: _____

Primary Insurance Information

Insurance plan name: _____
ID/certification number: _____
Policy/Group number: _____
Insurance plan phone number: _____
Claims address: _____

Patient relation to policy holder: Self Spouse Parent Other
Policy holder name (if different than patient): _____
Policy holder address: _____
Policy holder gender: M or F
Policy holder DOB: _____ Policy holder SSN: _____
Policy holder employer:_____

Secondary Insurance Information

Insurance plan name: _____
ID/certification number: _____
Policy/Group number: _____
Insurance plan phone number: _____
Claims address: _____

Patient relation to policy holder: Self Spouse Parent Other
Policy holder name (if different than patient): _____
Policy holder address: _____
Policy holder gender: M or F
Policy holder DOB: _____ Policy holder SSN: _____
Policy holder employer:_____

I hereby authorize Alamo Family Practice to release any pertinent medical information which may include information concerning mental conditions, alcohol and/or drug abuse, that is necessary for the processing of claims to my medical insurance, and request reassignment of insurance benefits either to myself of on 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 ultimately financially responsible for all the charges whether or no covered by the insurance.

Signed _____ Date _____