

ALLIANCE CLINICAL ASSOCIATES, S. C.

Registration Information

(Please Print)

Date: Home Phone: Cell Phone: Wk Phone:

Patient Last Name (Must be Legal Name) First Name Initial

Street Address:

City: State: Zip:

Sex: M F Age: Date of Birth: Social Security #

Single Married Widowed Separated Divorced

Whom may we thank for referring you?

In case of emergency, whom should be notified? Phone:

Purpose of Visit:

Your Pharmacy Name: Phone #:

Known Medical Problems:

Allergies:

Church or Religious Affiliation:

Signature of Patient:

If patient is a minor, I consent for my minor child to be treated at Alliance Clinical Associates.

Signature of Parent:

Do you have Medical Insurance? No Yes Medicare 2nd Insurance

Insurance Information of Policy Holder
Insurance Company: Phone
Address: Policy # Group #
Policy Holder Name Soc. Sec. #
Date of Birth Employer
Employer Address Employer Phone

Person Responsible for Payment of this Account (Guarantor)

Guarantor Name Relationship to patient
Street address
City State Zip
Home Phone Cell Phone Wk Phone
Guarantor's employer
Employer's address
Occupation
Guarantor's Social Security # Guarantor's Driver's License #

As guarantor for this account, I acknowledge my responsibility for payment on this account until revoked by me in writing. I have received ACA's financial policy statement.

Guarantor's Signature

Diagnosis Code: