ALLCARE MEDICAL CENTERS, P.C.
PATIENT INFORMATION/AUTHORIZATION TO TREAT

PATIENTS NAME_______________________________ DATE OF BIRTH_____________ AGE _____

MAILING ADDRESS_______________________________ CITY_______________ ZIP__________

HOME PHONE (____)_______________CELL PHONE (____)_______________ SEX: M OR F

PATIENT SSN_______-_______-_________ DRIVER'S LICENSE#_______________________

PATIENT EMPLOYER____

OCCUPATION_______________________________ WORK PHONE (___) ___________

REFERRING PHYSICIAN____________________ PRIMARY PHYSICIAN__________________

DATE OF INJURY_________________ DATE OF SURGERY_________________________

PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP__________________

FIRST AND LAST NAME___________________________ PHONE(____)______________

****IF PATIENT IS A MINOR PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION**:

PARENT/GUARDIAN NAME___________________________ SSN_______-_______-_______

PARENT/GUARDIAN EMPLOYER_______________________ WORK PHONE(____)__________

INSURANCE ____ ***please present card @ time of service***

WAS THIS A MOTOR VEHICLE ACCIDENT__________**IF YES PLEASE COMPLETE THE FOLLOWING**

NAME OF VEHICLE INSURANCE_______________________ PHONE (____)______________

NAME OF PERSON INSURED_______________________ ADJUSTER NAME _______________

ACCIDENT CLAIM#______________________

****PLEASE INITIAL THE FOLLOWING:**

_____ **I HEREBY AUTHORIZE ALLCARE MEDICAL CENTERS, P.C. TO PROVIDE TREATMENT AS PRESCRIBED BY MY PHYSICIAN.**

_____ **I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO BE PAID DIRECTLY TO ALLCARE MEDICAL CENTERS, P.C..**

_____ **I UNDERSTAND THAT IF MY INSURANCE CO/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYMENT I AM RESPONSIBLE FOR THE BALANCE DUE.**

_____ **I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO ALLCARE MEDICAL CENTERS, P.C. AND ANY PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.**

_____ **I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY ALLCARE MEDICAL CENTERS, P.C. INSURANCE IS BEING BILLED AS A COURTESY. I AM RESPONSIBLE FOR PAYING ANY DEDUCTIBLE OR CO-INSURANCE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

SIGNATURE OF PATIENT/PARENT/GUARDIAN________________________ **DATE**__________