PATIENT

Alivio Medical Center

First Name _____ **Last Name** _____

Date of Birth: **Month** _____ **Day** _____ **YR** _____ **TEL:** (_____) _____ - _____

Address _____ _____ _____ _____ _____
Nº Street Apt/Lot City State Zip Code

SSN: _____

E mail: _____

Sex: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

MINOR PATIENT (UNDER 18)

RESPONSIBLE: ☐ **FATHER** ☐ **MOTHER** ☐ **OTHER**

First and Last Name _____

Date of birth _____

Relationship to patient: _____

Emergency Contact:

Name: _____ Tel.: (_____) _____

Name: _____ Tel.: (_____) _____

HEALTH INSURANCE: ☐ NO ☐ YES

PLEASE PROVIDE THE INSURANCE ID CARDS ALONG WITH A PICTURE ID IN ORDER TO VERIFY COVERAGE "BEFORE" YOUR CONSULTATION

Who is the insured? ☐ Patient ☐ Parents/Spouse:

Name _____

Date of Birth: ____/____/_____ SSN: _____

Additional policy? ☐ No ☐ yes:

Secondary Ins:_____

ID _____ GRP_____

ACCIDENT: ☐ NO ☐ YES

☐ **AUTO** ☐ **WORK** ☐ **OTHER** _____

Date of injury _____

Have you received any treatment for this case elsewhere?
☐ No ☐ Yes:

☐ MD- physician ☐ Chiropractor ☐ Physical Therapy
☐ other: _____

Have you hired any attorney? ☐ No ☐ yes:
Name: _____ Tel: _____

CONSENTS: (Please read and initial in each line)

1) MEDICAL TREATMENT: I authorize Alivio Medical Center to provide a complete a medical evaluation and corresponding treatment. _____

2) CONSENT TO PROVIDE INFORMATION / FINANCIAL AGREEMENT: I authorize Alivio Medical Center to share/send the information needed to complete the billing process to insurance company, attorney, etc. _____

3) I UNDESTAND THAT I AM FINANCIALY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY MEDICAL INSURANCE. IN OTHER WORDS, I WILL PAY ALL NECESSARY COSTS FOR CONSULTATION, TEST, EXAMS AND ANY TREATMENS DONE IN THE OFFICE _____

4) HIPPA: I authorize to disclose my health information, as well to obtain payment for the medical care received. I have the right to review and secure a copy of the Notice of Privacy Practices, which contains more details. _____

SIGNATURE: _____ DATE: _____