Patient Registration Information

304 S. Mt. Auburn Road
Cape Girardeau, MO 63703
573-803-3331
www.alliancehealthmo.com

Last Name ______________________________ First Name ______________________________ MI _____

Date of Birth _______________________ Age _____ Gender _____

Street Address___________________________________ City ____________________________________

State ______________ Zip Code _____________ Email ____

Phone (H) _____________________ Phone (C) _____________________ Phone (W) ____________________

Employer ___________________________ Occupation ______________________________

Emergency Contact Name ______________________________ Phone Number _________________________

Preferred Pharmacy Name _____________________________ Pharmacy Number ______________________

Primary Care Physician _______________________________ Phone Number __________________________

Responsible Party (if younger than 18 years of age)

Name _____________________________ Relationship _____________ Phone Number___________________

Full Address ____

DOB _______________________ SSN _______________________ Employer ________________________

AUTHORIZATION/WAIVER OF BENEFITS

I hereby authorize the release of any information necessary to complete and process my insurance claims. I understand that it is my responsibility to obtain all necessary referral from my PCP prior to my visit. If services are denied due to lack of referral, I am responsible for payment in full. I also understand that I am responsible for payment of my account in full or for the portion not covered by my insurance. Finally, I understand that I will be responsible for 100% of all cosmetic charges incurred in this office.

Print Name: ____ Date: _____________________________

Signature: ____ Date: _____________________________