



Today's Date:	Have you been here before? Yes ____ No ____	Family Doctor:
Reason for visit today:		Preferred Pharmacy:
Is this work related? Yes ____ No ____ If yes, Supervisor's name:		
Employer Name/Address:		Date of Injury:

PATIENT INFORMATION

Patient's First Name:		Last:	Middle:
Birth Date:	Gender: Female ____ Male ____		
Race/Ethnicity: Caucasian ____ African American ____ Asian ____ Pacific Islander ____ Spanish/Hispanic Origin ____ Other ____ Decline ____			
Street Address:		City:	State: Zip:
Home Phone:	Cell Phone:	Work Phone:	
Social Security #:	YES! Sign me up for the AllBetterCare Newsletter to receive a brief survey about your visit. Email Address:		
Chose clinic because/referred to clinic by (Please check one): Dr. Referral ____ Insurance Plan ____ Clinic Sign ____ Billboard ____ Newspaper/Magazine ____ School ____ Family/Friend ____ Google Search ____ PennLive ____ Cumberlink ____ Direct Mail ____ Been Here Before ____ Employer ____			

INSURANCE

Is the patient covered by insurance? Yes ____ No ____	Primary Insurance	Secondary Insurance
Policyholder's Name & Address if Different from Patients:		
Policyholder's Birth Date:		
Patient Relationship to Policyholder:		
For Tricare Insurance please write sponsors SS#:		

IN CASE OF EMERGENCY

Do you give consent for AllBetterCare to discuss medical care with this contact per the HIPAA Laws? Yes ____ No ____		
Name of emergency contact:		
Relationship to patient:	Home Phone:	Work Phone:

FINANCIAL RESPONSIBILITY

Who is the responsible financial party for any personal balances due? ____ Patient ____ Other (Please fill in below)		
Name:	Address:	Telephone Number:

With my electronic signature, I attest that the above information is accurate and true to the best of my knowledge. I have read, understood, and agree with the AllBetterCare HIPAA, privacy, treatment, and payment policy. I authorize my insurance benefits to be paid directly to the physician for any treatment directed or rendered by AllBetterCare. I understand that I am financially responsible for any balance. I also authorize AllBetterCare or insurance company to release my information required to process my claims.