ALPHA MED
PHYSICIANS GROUP, LLC

Dear Patient,

On behalf of the physicians and staff of Alpha Med Physicians Group, we would like to welcome you to our practice. We realize that you have choices, and we appreciate that you have entrusted us with your care. We will strive to make your visit as pleasant and comfortable as possible. We have included a New Patient Packet to streamline the registration process. Please complete the following enclosed forms:

Patient Information Form: Provides us with up-to-date information.

HIPAA Authorization Form: Indicates to whom we may release your medical information and the method of contact.

HIPAA Consent Forms: Acknowledges that we have provided you with a copy of our Notice of Privacy Practices Form.

Pharmacy Consent Form: We prefer to e-prescribe your prescriptions for fast and accurate dispensing. This form allows us to electronically submit prescriptions to your pharmacy of choice.

In addition to the forms above, please bring the following to your appointment:

*All pertinent test results provided by your doctor.

*Current list of all medications, including over-the-counter and herbal supplements. You may bring the medication bottles instead of a list, if you prefer.

*List of questions or concerns that you would like to discuss with the doctor.

*Most recent insurance and prescription cards along with a photo I.D., and a referral from your primary care physician when necessary.

We welcome and encourage family and friends to accompany you to your visit. For the safety of our patients and staff, Alpha Med Physicians Group asks that you try to limit visitors to one or two people.

Please note that we do not allow children in the Lab. Children must remain in the Lobby area under the supervision of a parent or guardian at all times.

If there is anything that we can do to make your visit more pleasant, or if you need assistance or clarification, please do not hesitate to contact any of our staff members.

Thank you for choosing Alpha Med Physicians Group.

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Patient Information Form

Name:_____**Date:**_____

Home Address:_____ **SSN#:**_____-_____-_____

City:_____ **State:**_____ **ZIP:** _____

Home Phone:_____ **Work Phone:** _____ **Cell Phone:** _____

Birthdate: _____**Marital Status:** _____ **Name of Spouse:** _____

Email Address:_____

Patient's Occupation: _____**Patient's Employer:** _____

Patient's Primary Care Physician: _____

Patient Allergies: (drug, latex, environmental):_____

Emergency Contact: _____**Relationship:** _____

Emergency Contact Phone Number(s):_____

The U.S. Government requests this information in connection with this practice's implementation of electronic health records. If you do not wish to provide this information, please indicate by writing "refused" and initial each question.

Language Spoken: _____ **Race:** _____ **Ethnicity :☐ Hispanic OR ☐ Non-Hispanic**

Insurance Information:

***Primary* Insurance:** _____ **Name of Policy Holder:** _____

Policy Number: _____**Group Number:** _____

Eligibility Telephone Number: _____**Patient's Relationship to Policyholder:** _____

Date of Birth: _____**SSN:** _____ **Co-pay Amount:** _____

***Secondary* Insurance:** _____ **Name of Policy Holder:** _____

Policy Number: _____**Group Number:** _____

Eligibility Telephone Number: _____**Patient's Relationship to Policyholder:** _____

Date of Birth: _____**SSN:** _____ **Co-pay Amount:** _____

I have provided medical insurance information and copies of my insurance card(s). I authorize payment of medical benefits to Alpha Med Physicians Group, LLC. I authorize the release of any medical information necessary to process my claims.

X_____

I authorize release of my medical tests and/or records to Alpha Med Physicians Group, LLC.

X_____