Alliance Behavioral Medicine, LLC
4048 Laurel St. Suite 101
Anchorage, AK 99508
Tel: (907) 562-0001 Fax: (907) 562-0017

Today's Date ___________

# PATIENT REGISTRATION FORM

*PLEASE PRINT*

Referred By: ______________________________________________ .

PATIENT INFORMATION

Last Name:_________________________ First Name:_________________________ M.I.:_______

Marital Status: M / S / D SSN: ____________________ DOB: ___________ Age:_________ Sex: M / F

Physical Address: ____________________ City:__________________ State:_______ Zip:________

Mailing Address:______________________ City:__________________ State:______ Zip:________

Home Phone: ____________________ Cell Phone:____________________ Work Phone:____________________

Employer's Name:__________________________________________________

Emergency Contact:__________________________________________________

Name: ____________________ Address: ____________________ Phone:____________

PARENT/GUARDIAN/RESPONSIBLE PARTY : ***Who is responsible for the bill?***

Last Name: _________________________ First Name: _________________________ M.I.:_____

Relationship to Patient:__________________________________________________

Marital Status: M / S / D SSN: ____________________ DOB: ___________ Age:_________ Sex: M / F

(Mailing) Address: ____________________ City:__________________ State:_______ Zip:_________

Home Phone: ____________________ Cell Phone:____________________ Work Phone:____________________

Employer's Name:__________________________________________________

PRIMARY INSURANCE

Policy Holder: _________________________ Relationship to Patient: ____________________

SSN: _________________________ Date of Birth: ____________________ M _____ F _____

Insurance Name & Address: __________________________________________________

Policy #/ID: ____________________ Group #: ____________________ Effective Date:_________

Employer Name: __________________________________________________

SECONDARY INSURANCE

Policy Holder: _________________________ Relationship to Patient: ____________________

SSN: _________________________ Date of Birth: ____________________ M _____ F _____

Insurance Name & Address: __________________________________________________

Policy #/ID: ____________________ Group #: ____________________ Effective Date:_________

Employer Name: __________________________________________________

Has any member of your immediate family been treated by Dr. Nassar before?____________________
If yes, under what name?

I hereby authorize my insurance benefits to be paid directly to Alliance Behavioral Medicine, LLC, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to the insurance carriers and the billing agency utilized by Alliance Behavioral Medicine, LLC in order to bill my insurance company(s).

Patient / Parent / Legal Guardian Signature: Date:

_________________________________________ ____________________