



2045 Rama Dr., Suite 200, Indianapolis, IN 46219  
Tel.: (317) 635-3499 Fax: (317) 635-0449

**1. PATIENT INFORMATION**

Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
N° Street Apt. # City State Zip Code  
Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Sex:  Female  Male DOB: ..... - ..... - ..... Social Security # \_\_\_\_\_  
Month Day Year  
E-mail \_\_\_\_\_ Marital Status  Single  Divorced  Married  Widow  
Employer \_\_\_\_\_ Position \_\_\_\_\_  
Employer Telephone \_\_\_\_\_ Employer Address \_\_\_\_\_

**2. ACCIDENT INFORMATION**

Accident  Yes  No (If this is an accident case you must fill out an additional form)  Work-related  Auto  Other

**2. IN CASE OF EMERGENCY** (People who do not live in the same home)

Nombre \_\_\_\_\_ Tel (\_\_\_\_\_) \_\_\_\_\_ Nombre \_\_\_\_\_ Tel (\_\_\_\_\_) \_\_\_\_\_

**3. RESPOSIBLE PARTY** (If the patient is a minor or a student under the age 21, or if your spouse has health insurance)

Full Name \_\_\_\_\_ Address \_\_\_\_\_  
Social Security # ..... - ..... - ..... DOB ..... - ..... - ..... Tel (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year  
Relation to the Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Position \_\_\_\_\_ Employer Telephone \_\_\_\_\_

**4. INSURANCE INFORMATION**

Medicare # \_\_\_\_\_ Other Insurance \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_ ID # \_\_\_\_\_  
DOB \_\_\_\_\_ Relation to the Patient \_\_\_\_\_

**5. ADDITIONAL INSURANCE INFORMATION**

Is the patient covered by another policy?  Yes  No Company \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_ ID # \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT**

I authorize Alivio Medical Center's staff to provide medical care

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT TO PROVIDE INFORMATION/FINANCIAL AGREEMENT**

I authorize Alivio Medical Center to send information needed to complete the billing process to the insurance company. I am aware that I am fully responsible for all charges whether covered or not by my insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT**

If you have health insurance coverage, please provide the receptionist your insurance card so she may verify benefits and eligibility.