

Alpha Advanced CT, LLC

7 Rathton Road
York PA 17403
717-505-5070

PERSONAL INFORMATION	Patient Last/First Name: _____			Sex: M / F	Age: _____	Date: _____	
	Street: _____			Apt/ PO Box: _____			
	City: _____		State: _____		Zip: _____		
	Home Phone: _____			Work Phone: _____			
	SS #: _____			Date of Birth: _____			
	Employer: _____			Spouse/Guardian: _____			
	Emergency Phone: _____			Emergency Contact: _____			
	Primary Physician: _____			Referring Physician: _____			
	PLEASE LIST ALL KNOW ALLERGIES: _____						
	Responsible Party: _____						
Address: _____ Phone: _____							
INSURANCE INFORMATION	PRIMARY						
	Insurance Company: _____			Policy: _____	Group: _____		
	Billing Address: _____						
	SS#: _____			Subscriber Name: _____			
	Relationship to Patient: _____			Subscriber Address: _____			
	SECONDARY						
	Insurance Company: _____			Policy: _____	Group: _____		
	Billing Address: _____						
SS#: _____			Subscriber Name: _____				
Relationship to Patient: _____			Subscriber Address: _____				
Workers Compensation	WORKERS COMPENSATION						
	Insurance Company: _____			Policy/Claim: _____			
	Address: _____			Employer: _____			
				Employer Address: _____			
Date/State of Accident: _____			Employer Phone: _____				
Automobile Information	AUTOMOBILE ACCIDENT						
	Insurance Company: _____			Policy/Claim: _____			
	Address: _____			Adjuster: _____			
	Date/State of Accident: _____			Adjuster Phone: _____			

Co-Pay Payment: _____