Alzheimer's Memory Center

485 North Wendover Road
Charlotte, NC 28211
704-364-4000 Fax: 704-364-4005

Date _____ Primary Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SSN # _____
Last Name First Name Middle Initial

Address _____

City _____ State ____ Zip _____ Birthdate : _____

Pharmacy Name: _____ **Telephone** # : _____

Pharmacy Address: _____

Emergency Contact/Caregiver: _____ Phone (____)

PRIMARY PHYSICIAN INFORMATION (Information Needed)

DR. Name _____

Address _____

Facility Name _____

City _____ State _____ Zip _____

Telephone Number _____ Fax # _____

INSURANCE INFORMATION

Insurance Name _____Policy #_____
Have you change insurance company since your last visit to our office? ___ yes or ___ no
Are you currently under Hospice care? ____ If yes, please provide the following information:

Facility Name _____

Address_____ Phone#_____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of insurance company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient