

**REGISTRATION**

(PLEASE PRINT)

**Alzheimer's Memory Center**

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

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ SSN # \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex M F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Married Widowed Single Minor  
Separated Divorced Partnered for \_\_\_\_ years

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School # (\_\_\_\_) \_\_\_\_\_

Caregiver's Name: \_\_\_\_\_ Caregiver's Telephone # \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**PRIMARY PHYSICIAN INFORMATION**

DR. Name \_\_\_\_\_

Address \_\_\_\_\_

Facility Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

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

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Please print name of Patient, Parent, Guardian or Personal Representative

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Relationship to Patient