Altoona Arthritis and Osteoporosis Center
Altoona Center for Clinical Research
Altoona Specialty Center
Meadowbrook Sleep Center
175 Meadowbrook Lane
Duncansville, PA 16635
Phone: (814) 693-0300 / (814) 296-6113 Fax: (814) 696-1882

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip Code)

Telephone Number: _____ Date of Birth: _____

Cell Phone/Other: _____ Email Address: _____

Social Security Number: _____ Present Age: _____ Sex: _____

Race: White ☐ Black ☐ Asian ☐ Indian/Alaskan ☐ Pacific Islander ☐ Other ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Declined ☐

Marital Status: M ☐ S ☐ W ☐ D ☐ Spouse's Name: _____

Spouse's Date of Birth: _____ Spouse's Social Security: _____

Patient's Employer: _____ Telephone: _____

Spouse's Employer: _____ Telephone: _____

Parent's Name (If patient is under 18): _____

Emergency Contact: _____ Telephone: _____

Pharmacy Name/Telephone: _____

Name of Medical Physician: _____ Telephone: _____

Name of Physician/friend referring you to our office and address: _____

Insurance Coverage or Workman's Compensation or Auto Accident

Insurance Coverage: _____
(Name of Insurance Plan)

Policy #: _____ Group #: _____

Medicare #: _____

Date of Injury if Workman's Comp. or Auto Accident: _____

Patient, insured, authorized signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.
I authorize payment of medical benefits to the physician or supplier for services rendered. A fee of $10.00 will be added if an outside collection service is necessary.

Signature: _____ Date: _____