

**ALPINE MEDICAL ASSOCIATES**

1667 Lucerne Street, Suite A

Minden, NV, 89423

**Steven M. Brown, M.D.**

Last Name:		First Name:		M.I.	Social Security		D.O.B.
Mailing Address				City, State, Zip			
Physical Address				City, State, Zip			
Home Phone		Work Phone		Sex		Marital Status	
Employer or School		Work/School Phone		Work/School Phone		City, State, Zip	
Spouse/Parent Last Name		First		M.I.	Date of Birth		Sex
Relationship to Patient		Social Security Number			Drivers License Number		
Employer				Work Phone			
Employer Address				City, State, Zip			
In Case of Emergency (not related)				Home		Work	
Primary Insurance		Address		City, State, Zip		Insurance Phone	
Name of Insured		Address		City, State, Zip		Insured Phone	
ID # Group #		Social Security		Relationship		Insured Employer	
Secondary Insurance		Address		City, State, Zip		Insurance Phone	
Name of Insured		Address		City, State, Zip		Insured Phone	
ID# Group #		Social Security		Relationship to Patient		Insured Employer	

**ACCIDENT OR INJURY INFORMATION**

Accident <input type="checkbox"/> Y <input type="checkbox"/> N		Accident Date	Injury Date	Workers Comp <input type="checkbox"/> Y <input type="checkbox"/> N	Auto <input type="checkbox"/> Y <input type="checkbox"/> N	Slip/Fall <input type="checkbox"/> Y <input type="checkbox"/> N	Other- Specify
Employment Related Current <input type="checkbox"/> Previous <input type="checkbox"/>	Name of Employer		City	State	Zip		

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment directly to the above signed physician for the medical benefits, if any, otherwise payable to me for services described. I hereby authorize the above-signed physician to release any information necessary to process this claim

Signed \_\_\_\_\_

Date \_\_\_\_\_