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 □Y □N	Accident Date	Injury Date	Workers Comp □Y □ N	Auto □ Y □N	Slip/Fall □Y □N	Other-Specify

Employment Related Current □ Previous □	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_____