

Allegra Family Clinic

1116 Mitt Lary Road • Northport, AL 35473
Phone: 205-556-5634 • Fax: 205-556-5644



Allegra Wellness

4804 SR-69N • Northport, AL 35476
Phone: 833-633-5874

PLEASE PRINT CLEARLY

Name _____
If Married, Maiden Name _____
Social Security # _____
Date of Birth (MM/DD/YYYY) _____
Marital Status (check one)
married single domestic partner
Gender at birth (check one) male female
Race _____
Ethnicity _____ Language _____

Physical Address

Street _____
City _____ State _____ Zip _____

Mailing Address (if different)

Street _____
City _____ State _____ Zip _____

Home Phone (_____) _____
Mobile Phone (_____) _____
Work Phone (_____) _____
Email _____
Pharmacy _____

Method of appointment reminders (check one)

Email Text Phone

How did you here about us:

Radio Billboard Website Social Media
Referral/Friend _____

Responsible Party self other

If other, Name _____
Relationship to patient _____
Mailing Address _____

Phone # _____
Insured DOB _____
Email _____

Emergency Contact responsible party other

If other, Name _____
Relationship to patient _____
Mailing Address _____
Phone # _____

Primary Insurance Co. _____
Plan Name _____
Plan Type _____
Group Name _____
Group # _____
Policy # (ID#) _____
Start/Effective Date _____
Office Copay \$ _____

Secondary Insurance Co. _____
Secondary Group # _____
Secondary Policy # _____

HIPPA INFORMATION

Please allow my medical information to be shared with the following: (NAME, DOB, RELATIONSHIP)

Have you had the following vaccines? (check all that apply)

Flu Shingles Pneumonia Hep B Other
Covid ____1st ____2nd ____Booster Tetanus ____

List the Medications you are currently taking:

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I agree to be notified of all health information and test results via text message: (initial) _____

I opt out of text messaging and prefer to be notified by phone: (initial) _____

PAST MEDICAL HISTORY

Condition	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you use tobacco?	YES	NO
Do you drink alcohol?	YES	NO
Do you use illicit drugs?	YES	NO
Do you eat healthy meals?	YES	NO
Do you exercise regularly?	YES	NO
Do you take a daily aspirin?	YES	NO

Do you have, or have you ever had, any of the following:

- _____ Diabetes ___ Foot Exam ___ Eye Exam
- _____ High Blood Pressure
- _____ High Cholesterol
- _____ Hypothyroidism
- _____ Goiter
- _____ Cancer (type) _____
- _____ Leukemia
- _____ Psoriasis
- _____ Angina
- _____ Heart Problems
- _____ Heart Murmur
- _____ Pneumonia
- _____ Pulmonary Embolism
- _____ Asthma
- _____ Emphysema
- _____ Stroke
- _____ Epilepsy (seizure)
- _____ Cataracts
- _____ Kidney Disease
- _____ Kidney Stones
- _____ Crohn's Disease
- _____ Colitis
- _____ GERD/Heartburn
- _____ Anemia
- _____ Jaundice
- _____ Hepatitis
- _____ Stomach or peptic ulcer
- _____ Tuberculosis
- _____ HIV/AIDS
- _____ Migraine Headaches
- _____ Depression
- _____ Anxiety
- _____ Other _____

If Male:

Date of last PSA _____
 Date of last Colonoscopy _____
 Personal or family history of prostate cancer? YES NO
 Any issues with erectile dysfunction? YES NO

If Female:

Date of onset of last menses _____
 Date of last PAP Smear _____
 Date of last Mammogram _____
 Date of last Bone Density Scan _____
 Date of last Colonoscopy _____

Have any of your family had any of the following?

- _____ arthritis
- _____ asthma
- _____ bleeding disorder
- _____ heart disease
- _____ diabetes
- _____ high cholesterol
- _____ hypertension
- _____ lung disease
- _____ mental illness
- _____ osteoporosis
- _____ stroke
- _____ cancer (if yes, what type(s))

- _____ other _____

Surgeries:	Type	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all allergies (if none, check the blank below):

No known allergies _____
 Medications _____

 Foods _____

 Other _____

Hospitalization History:

Reason	Length of Stay	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I acknowledge that I have been provided Allegra Clinic's Notice of Privacy Practices

Signature _____
 Date _____

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Name _____

Date _____

NO SHOW AND CANCELLATION POLICY

I understand that if i fail to show up for my appointment without a 24 hour notice, i may be subject to a “no show” fee of \$20 that is not billable to insurance.

FINANCIAL POLICY

I understand that charges incurred for services rendered by Allegra Family Clinic are my responsibility, regardless of insurance coverage. I understand and agree that insurance policies are and agreement between the insurance carrier and me; and not between my insurance carrier and Allegra Family Clinic. Furthermore, I understand Allegra Family Clinic will prepare any necessary reports and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to Allegra Family Clinic will be credited to my account upon receipt.

Assignment will be accepted for all insurance with which Allegra Family Clinic participates. It is my responsibility to provide this office with accurate insurance information and to notify Allegra Family Clinic of any changes in health insurance coverage. If I have any questions on network status/participation with my insurance, it is my responsibility to contact the customer service number on my insurance card.

I understand if any insurance company sends a check or reimbursement to me, THE CHECK DOES NOT BELONG TO ME. I am to bring the check and Explanation of Benefits to Allegra Family Clinic.

PATIENT RESPONSIBILITY

If my insurance has an office co-payment, co-insurance, or deductible that has not been satisfied, I must pay this at the time of my appointment. I understand that charges for professional services rendered are due and payable immediately. Any amount unpaid by my insurance company is my responsibility and is due immediately upon notification on the denial by my insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All cost for my care is my responsibility. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect.

BILLING: KNOW YOUR INSURANCE POLICY

I understand that I am responsible for any rejected claims, non-covered expenses, deductibles, and co-insurance/co-payments. Cash, money order, Visa and MasterCard are acceptable means in which to pay the balance.

I understand that at times, no matter how diligent Allegra Family Clinic’s billing may be, my insurance company might decline a claim for services. In that event, it is most effective for me to contact the insurance company since I am their paying customer. Allegra Family Clinic’s billing department will be glad to assist me, but I may be asked to intervene as this is the most effective means of settling disputes with my insurance company.

If there remains an unpaid balance and I make no payment or make no contact as the responsible party despite all Allegra Family Clinic’s efforts to contact me, then my account could be turned over to collections or pursued legally.

Informing our patients about our financial policy assists us in providing the best service to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please kindly contact our Business Office Supervisor.

I hereby understand the financial policy of this practice. I guarantee payment of all charges incurred for the account of the patient names below. I further agree to pay any attorney’s fees, court costs, and related collection fees incurred. I also agree that my employer may be contacted to verify employment status.

Patient’s Name/Signature _____ Date _____

Guarantor/Responsible Party Signature _____ Date _____