Altoona Arthritis and Osteoporosis Center
Altoona Center for Clinical Research
Altoona Specialty Center
Meadowbrook Sleep Center

1125 Old Route 220 North
P.O. Box 909
Duncansville, PA 16635
Phone: (814) 693-0300 Fax: (814) 696-1882

Name: _____
(Last) (First) (Middle Initial)
Address: _____
(street) (city) (state) (zip code)
Telephone Number: _____ Date of Birth: _____
Cell/Other:_____ Email:_____

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

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 Names (If patient under 18):_____

Emergency Contact:_____ Telephone:_____

Pharmacy Name/Telephone:_____

Name of Physician:_____ Telephone:_____

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

Insurance Coverage

Insurance Coverage: _____
(Name of Insurance Plan)
Policy #:_____ Group #:_____

Medicare #:_____

Patient, insured, authorized person's 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: _____