



Welcome to Our Office

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Patient Information

Date _____ Age _____

Name	Social Security Number	Marital Status S M D	Sex	Race	Date of Birth
Address	City, State	Zip Code	Home Telephone Number		
Cell Number	Employer	Employer Telephone Number			
Emergency Contact Name / Relationship (not living with you)			Telephone Number		
Pharmacy			City of Pharmacy		

If Minor, Complete This Section

Name of School				
Father's Name	Employer	Social Security Number	DOB	Telephone Number
Mother's Name	Employer	Social Security Number	DOB	Telephone Number

Please Read: Co-payment on office visit due today.

Person Responsible for Payment	Address, City, State	Zip Code			
Telephone Contact Numbers (Home)	(Cell)	(Work)			
Primary Insurance	Contract Number	Group	Policy Holder's Date of Birth		
Policy Holder's Name	Policy Holder's Employer	Policy Holder's Employer Telephone			
Secondary Insurance	Contract Number	Group	Policy Holder's Date of Birth		
Policy Holder's Name	Policy Holder's Employer	Policy Holder's Employer Telephone			
Injury: Where were you injured at:	<input type="checkbox"/> Work	<input type="checkbox"/> Auto	<input type="checkbox"/> Home	<input type="checkbox"/> Other	<input type="checkbox"/> Illness
Date of the Accident					
Please tell us who you were referred by.					

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper.

I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also agree to pay costs of collections, including attorney's fees and waive my exemption under the constitution and laws of the state of Alabama.

I hereby authorize Orthopedic & Sports Medicine Specialists of Cullman to furnish information to insurance carriers and referring physicians concerning my illness and treatments.

Signature _____ Date _____