

PATIENT INFORMATION					
PATIENT'S LAST NAME		FIRST	MIDDLE	DATE OF BIRTH	AGE
STREET ADDRESS			CITY	STATE	ZIP CODE
DRIVER'S LICENSE #	HOME PHONE	CELL PHONE	WORK PHONE	EMAIL	
PATIENTS EMPLOYER			<input type="checkbox"/> FULL TIME <input type="checkbox"/> NONE <input type="checkbox"/> STUDENT <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED	EMPLOYER PHONE	
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D		DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	SOCIAL SECURITY #	
PREFERRED LANGUAGE		RACE		ETHNICITY	
SPOUSE'S NAME		EMPLOYER		EMPLOYER PHONE	
REFERRING PHYSICIAN		ADDRESS		PHONE	
PRIMARY CARE PHYSICIAN		ADDRESS		PHONE	
PHARMACY NAME		LOCATION		PHONE	
INSURANCE INFORMATION					
P R I M A R Y	PROVIDER		POLICY HOLDER		POLICY HOLDER SEX <input type="checkbox"/> M <input type="checkbox"/> F
	POLICY HOLDER EMPLOYER		EMPLOYER'S PHONE	INSURED'S SOCIAL SECURITY #	POLICY HOLDERS DOB
	CONTRACT NUMBER		GROUP NUMBER	RELATIONSHIP OF PATIENT TO INSURED	EFFECTIVE DATE
S E C O N D A R Y	PROVIDER		POLICY HOLDER		POLICY HOLDER SEX <input type="checkbox"/> M <input type="checkbox"/> F
	POLICY HOLDER EMPLOYER		EMPLOYER'S PHONE	INSURED'S SOCIAL SECURITY #	POLICY HOLDERS DOB
	CONTRACT NUMBER		GROUP NUMBER	RELATIONSHIP OF PATIENT TO INSURED	EFFECTIVE DATE
EMERGENCY CONTACT INFORMATION					
PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN SPOUSE)				RELATIONSHIP	
ADDRESS		CITY	STATE	ZIP CODE	PHONE NUMBER
INJURY INFORMATION					
JOB RELATED	DATE OF INJURY	DATE LAST WORKED	EMPLOYER AT TIME OF INJURY		
WORKMEN'S COMPENSATION CARRIER			WHERE WERE YOU INJURED		
HOW DID INJURY OCCUR?			EMPLOYER REPRESENTATIVE WHO AUTHORIZED TREATMENT		
EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES					

REFERRALS: I understand that a referral is necessary for any visits to a specialist's office and that it is my responsibility to assure the referral is obtained and current prior to the scheduled visit.

AGREEMENT TO PAY: I hereby assign and authorize payment to **Advanced Surgeons P.C.** any medical and surgical benefits otherwise payable to me. Should an insurance payment be less than the usual charge for services provided, I may be responsible for the difference.

I also agree to pay all cost of collection including, but not limited to reasonable attorney's fees, and waiver all claim of exemption under the law of the State of Alabama.

RELEASE OF MEDICAL RECORDS: I authorize **Advanced Surgeons P.C.** to request or release any medical information from or to another physician or medical institution as necessary for my medical care. I also authorize the release of medical information to my insurance company for filing purposes.

Signature of patient or responsible party

Date