North Alabama Bone & Joint Clinic, P.C.

SECTION 1 PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Age: _____ Birthdate: _____ Home Phone: _____ Marital Status: ☐S ☐M ☐D ☐W Sex: ☐M ☐F

Address: _____ City: _____ State: _____ Zip: _____ SSN: _____

Occupation: _____ Place of Employment: _____ Bus. Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Person to notify in Case of an Emergency Outside of Your Home: _____

Name: _____ Phone Number: _____

SECTION 2 RESPONSIBLE PARTY (If Different From Patient)

Last Name: _____ First Name: _____ Middle Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____ Home Phone Number: _____

Employer & Address: _____ Employer Phone: _____ SSN: _____

SECTION 3

PRIMARY INSURANCE	SECONDARY INSURANCE
Company: _____	Company: _____
Policy Number: _____	Policy Number: _____
Group Number: _____	Group Number: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's Place of Employment: _____	Policy Holder's Place of Employment: _____
Policy Holder's Date of Birth: _____	Policy Holder's Date of Birth: _____
Patient's Relationship to Policy Holder: _____	Patient's Relationship to Policy Holder: _____
Sex: ☐ M ☐ F	Sex: ☐ M ☐ F

SECTION 4

Were you referred by another Doctor? _____ Doctor's Name: _____

Who is your Medical Doctor? Name: _____

Please check one of the following: ☐ Work Related Injury ☐ Personal Injury ☐ No Injury ☐ Automobile Accident

Date of Injury/Onset: _____

AUTHORIZATION FOR SERVICES: The signature below serves as authorization for services rendered by North Alabama Bone & Joint Clinic, P.C. for the above named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier– a copy of the signature is as valid as the original.

AGREEMENT TO PAY: I, The undersigned, accept the fee(s) charged as a legal and lawful debt. I understand the fee(s) charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including up to a 33.33% collection fee, Attorney Fees, and/or Court Costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state. A fee of $30.00 will be charged for all returned checks.

AUTHORIZATION FOR RELEASE OF INFORMATION: The signature below serves as authorization for North Alabama Bone & Joint Clinic, P.C. to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original.

Date: _____ **Signature of Patient:** _____

(If Minor, Signature of Responsible Party)

Print Name: _____