



Patient's Full Name _____ Birthdate _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____ Cell Phone _____
 E-mail Address _____

Have you ever been seen by any of our physicians? Yes No

Emergency Phone # _____ Relative Friend Other

Patient's Social Security # _____ Retired Disabled

Patient's Employer _____ Work Phone _____

Employer Address _____ Phone Extension _____

Sex _____ Age _____ Married Divorced Separated Single Widowed

Responsible Party's Name _____

(Responsible Party Signature Required At Bottom of Form)

Address (if different) _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

S.S. # of Spouse of Patient or Spouse of Responsible Party _____

Primary Insurance Company _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ **Insured's Employer** _____ **Insured's Birthdate** _____

Contract # _____ Group # _____ Effective Date _____

*** How Much Is Your Co-Payment \$ _____

Secondary Insurance Company _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ **Insured's Employer** _____ **Insured's Birthdate** _____

Contract # _____ Group # _____ Effective Date _____

*** How Much Is Your Co-Payment \$ _____

*** Drug Allergies *** _____

Who Referred You To Birmingham Surgical ? _____

Who is Your Primary Care Physician ? _____

Your Pharmacy Name and Phone Number: _____

PAYMENT - IN FULL - DUE IN 90 DAYS REGARDLESS OF INSURANCE STATUS

In the event this account is not paid in full within 90 days, the undersigned agrees to pay all costs of collection including reasonable attorney fees/court costs. I understand that any "hold harmless" clause included in my insurance contract does not apply unless Birmingham Surgical is a member of the insurance plan. I also authorize release of medical records to patient's physicians and insurance carriers.

Date _____ Responsible Party's Signature _____

(Required)

