PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: ________________________ First Name: _____________________ Middle Name: _________________

Mailing Address: __________________________ Apt/Ste #: _____ City: __________ State: ____ Zip: _________

☐ **If street address is the same as mailing address, please check box.**

Street Address: ____________________________ Apt/Ste #: _____ City: __________ State: ____ Zip: _________

Date of Birth: ________ Age: _____ Sex: _____ Race: _____ Marital Status: _____ Soc. Sec. No. _____________

Home Phone: ____________________ Cell Phone: __________________ Work Phone No. ___________________

Employer: _____________________________________ Occupation: ____

Spouse's Name: ___________________________________ Spouse's Soc. Sec. No.: ____________________________

Spouse's Employer: ________________________________ Spouse's Bus. No.: _______________________________

Religious Affiliation: ____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN ABOVE)

Last Name: _________________________ First Name: ______________________ Middle Name: ______________

Street Address: ___________________________________ City: ____________ State: ______ Zip: ________________

Date of Birth: ______________ Soc. Sec. No.: _______________ Relationship to Patient: __________________

Employer: __________________________ Home Phone: __________________ Bus. Phone: __________________

INSURANCE INFORMATION – PLEASE PRESENT CARDS TO RECEPTIONIST

Name of Primary Insurance: ____

Contract/Policy Number: ______________________________________Group Number: _____________________

Subscriber: ________________________ Date of Birth: __________ Relationship to Patient: _________________

Name of Secondary Insurance: ____

Contract/Policy Number: ______________________________________Group Number: _____________________

Subscriber: ________________________ Date of Birth: __________ Relationship to Patient: _________________

Is this a Workmen's Compensation Claim? If yes, give accident date: ____________________________________

Name of Referring Physician: ____

I acknowledge and agree that I am fully responsible for payment of all charges for any services rendered by Surgical Specialists of AL, P.C., and for payment of any balance not paid by insurance when due, and I agree to pay any such charges. I further reaffirm and agree to pay all previously incurred and unpaid charges I may owe said Surgical Specialists of AL, P.C. If my account becomes delinquent, I agree to pay all costs of collections, including a reasonable attorney's fee of one-third (1/3) of the principal balance then due, if my account is placed with an attorney for collections; And I waive any right I may have according to the Constitution and the Laws of the State of Alabama to claim exemptions as to personal property as to this obligation.

I recognized that certain routine services necessary for the maintenance of good health may not be covered by my insurance carrier. I will be responsible for paying for these services in full at the time of the service, or when billed, if denied by my insurance carrier. I understand I am responsible financially to the physician for non-covered services. I authorize the release of any medical information necessary to other physicians who may participate in my care; and/or, to process my insurance claim filed for the services described. I allow fax transmittal of such records if necessary. I authorize payment of benefits directly to Surgical Specialists of AL, P.C., for services rendered to myself or my minor dependents.

Patient Email Address: ____

Signature ____ Date _______________________________