New Patient Form

Infectious Disease Specialists of North Alabama

250 Chateau Drive, Suite 115 · Huntsville, AL 35801

256.533.4645

DATE _____

Please fill out completely

Patient Information

Name:_____Sex: ☐ Male ☐ Female

Address:_____ City, State, Zip_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Driver's License # (indicate state)_____ D.O.B. _____/_____/_____ Age_____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Patient SSN:_____-_____-_____

Patient's Employer:_____ Work Phone # (_____)_____

Emergency Contact

Contact name:_____Relationship_____Phone # (_____)_____

Referring Physician

Referring Physician:_____Phone # (_____)_____

Insurance Information

Insurance # 1_____Employer_____

Contract #_____Group #_____Co-pay amount_____

Name of Insured_____Relationship to Patient_____

Insured's D.O.B. (mm/dd/yyyy)_____Insured's SSN_____ Sex: ☐ Male ☐ Female

Insurance # 2_____Employer_____

Contract #_____Group #_____Co-pay amount_____

Name of Insured_____Relationship to Patient_____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature_____**Date**_____

I hereby authorize Scott D. Parker MD LLC doing business as Infectious Disease Specialists of North Alabama to file for insurance benefits on my behalf for all covered services rendered by the office or by IDSONA's order. I request that payment from the insurance company be made directly to Scott D. Parker MD LLC. I certify that the information I have reported with regard to my insurance coverage is correct, and that I will be responsible for any charges my insurance does not cover. I permit a copy of this authorization to be used in place of the original.

Signature_____**Date**_____