Infectious Disease Specialists
of North Alabama
250 Chateau Drive Suite 115 · Huntsville, AL 35801 · 256.533.4645

PATIENT INFORMATION

Please fill out completely

Name:_____Sex: ☐ male ☐ female

Address:_____

City, State, Zip_____

Home Phone:_____ Cell Phone:_____Date of Birth:____/_____/_____

Patient SSN:_____ Driver's License #_____Age_____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient's Employer:_____Phone #_____

Referring Physician:_____Phone #_____

EMERGENCY CONTACT

Contact name:_____Phone #_____

Relationship to patient_____

INSURANCE INFORMATION

Insurance # 1_____Group #_____

Policy #_____Co-pay amount_____

Subscriber address (if different)_____SSN:_____

Insurance # 2_____Group #_____

Policy #_____Co-pay amount_____

Subscriber address (if different)_____SSN:_____

When registering, please provide current proof of insurance, Medicare and/or Medicaid. Payment is expected at the time of service unless special arrangements are made. We are required by Federal Law to collect co-payments.

I authorize the release of any medical information necessary to process claims on my behalf. I also request payment of benefits to be made to the physician or supplier. I also acknowledge that my insurance will be billed as a courtesy and if my insurance company for any reason denies any test or procedures, I am responsible to make payments in full to the physician who performed those services. In the event the bill is turned over to a collection agency, I acknowledge that I will be responsible for any collection fees and attorney fees accumulated in the collection process.

_____ _____

Signature of Beneficiary or person signing for Beneficiary Date Signed