ALABAMA INFECTIOUS DISEASE CENTER, P.C.
420 LOWELL DRIVE, SUITE 301
HUNTSVILLE, AL 35801
(256) 265-7955

PATIENT REGISTRATION INFORMATION

☐ **Dr. Ali A.M. Hassoun** ☐ **Dr. Hafsa Hassan Siddiqui**

PATIENT INFORMATION:

First Name: ________________________________ MI: _________ Last Name: ____

DOB: _______________________ Sex: __________ SSN #: _______________________

Marital Status (**S M W D**) Race:_____________Language:_____________

Address: ____ Apt#: ______________

City: _______________________________ State: __________ Zip: __________________

Home Phone: ____________________________________ Cell Phone: ___________________________________

Patient's Employer: _____________________________________ Employer's Phone #: _________________________

Employer's Address: ____

City: _______________________________ State: __________ Zip: __________________

Emergency Contact: ____________________________ Relationship: _________________ Phone #: __________________

PRIMARY CARE DOCTOR:____________________________________ REFERRING DOCTOR:______________________________

PHARMACY PREFERENCE: ______________________________________

EMAIL :____(allows access for patient portal information)

BILLING INFORMATION:

First Name: ______________________________ MI: _________ Last Name: _____________________________________

DOB: _______________________ Sex: __________ SSN #: _______________________

Address: ____ Apt#: ______________

City: _______________________________ State: __________ Zip: __________________

Home Phone: ______________________________________Cell Phone: ____

INSURANCE INFORMATION:

Primary Insurance: _________________________________ Policy Number: ______________________ Group #:________

Subscriber Name: __________________________________ Subscriber Sex: _________ Subscriber DOB:______________

Subscriber SSN #:__________________________________ Subscriber Employer:__________________________________

Secondary Insurance: _______________________________ Policy Number: ______________________ Group #:________

Subscriber Name: __________________________________ Subscriber Sex: _________ Subscriber DOB:______________

Subscriber SSN #:__________________________________ Subscriber Employer: __________________________________

I/We, the undersigned, hereby agree to pay all amounts and charges hereafter incurred by me or members of my family for services rendered by this office. I hereby authorize Dr.Hassoun and Dr. Siddiqui to furnish information to insurance carriers concerning my illness and treatments. It is customary that payment be made when the service is rendered unless prior arrangements have been made in advance. I authorize benefits payable to the above physicians. I understand that I am responsible for any amount not covered by insurance. In the event of non-payment, either by insurance or myself, I agree to pay all costs of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce and provision of this contract. I/We further agree to waive my/our rights of exception under the laws of the State of Alabama or any other state.

Date: ________________________ Signature: ____