ADVANCED INTERNAL MEDICINE P.C. - BIRMINGHAM, AL 35213

(PLEASE PRINT)

PATIENT REGISTRATION FORM

ACCOUNT NO - OFFICE USE ONLY

3263395
SRE
REBLU

PATIENT INFORMATION

DATE	SOCIAL SECURITY NO.	FIRST NAME	M.I.	LAST NAME

ADDRESS	CITY	ST	ZIP	COUNTY	DATE OF BIRTH

HOME PHONE NO.	VETERAN ☐ YES ☐ NO	WORK PHONE NO	EXTENSION	CELL PHONE NO.	GENDER ☐ MALE ☐ FEMALE	RACE

MARITAL STATUS S / M / W / D	OCCUPATION	WORK ADDRESS	CITY	ST	ZIP

E-MAIL ADDRESS	DRIVER'S LIC. NO.	STATE	REFERRED TO THIS OFFICE BY

RESPONSIBLE PARTY INFORMATION - IF DIFFERENT THAN PATIENT INFORMATION

RELATIONSHIP TO PATIENT	NAME OF RESPONSIBLE PARTY	SOC. SEC. NO.	DRIVER'S LICENSE NO.

STREET ADDRESS	ZIP CODE	CITY	STATE

HOME PHONE NO.	HOME WORK NO.	CELL PHONE NO.	NAME OF EMPLOYER (WORK)

EMPLOYER'S STREET ADDRESS	ZIP CODE	CITY	STATE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

NAME OF INS. CO.		
GROUP NO.	POLICY NO.	EFFECTIVE DATE
RELATIONSHIP TO PATIENT	NAME OF INSURED (AS IT APPEARS ON YOUR CARD)	
DATE OF BIRTH	INSURED'S EMPLOYER	CO PAY

SECONDARY INSURANCE COMPANY

NAME OF INS. CO.		
GROUP NO.	POLICY NO.	EFFECTIVE DATE
RELATIONSHIP TO PATIENT	NAME OF INSURED (AS IT APPEARS ON YOUR CARD)	
DATE OF BIRTH	INSURED'S EMPLOYER	CO PAY

INJURY INFORMATION

JOB RELATED ☐ YES ☐ NO	DATE OF INJURY	DATE LAST WORKED	EMPLOYER AT TIME OF INJURY

WORKMEN'S COMPENSATION CARRIER	WHERE WERE YOU INJURED?

HOW DID YOUR INJURY OCCUR?	EMPLOYER REP. WHO AUTHORIZED TREATMENT

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

PERSON TO CONTACT (OTHER THAN SPOUSE)	RELATIONSHIP	PHONE NO.

STREET ADDRESS	CITY	STATE	ZIP

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

I HEREBY AUTHORIZE ADVANCED INTERNAL MEDICINE, P.C. TO RELEASE ANY AND ALL INFORMATION ACQUIRED IN MY EXAMINATION, TREATMENT AND DIAGNOSIS TO MY INSURANCE CARRIERS AND OTHER TREATMENT PHYSICIANS. IF I AM COVERED BY BLUE CROSS, MEDICARE AND/OR MEDICAID I WILL FURNISH MY INSURANCE CARD AND SIGNATURE. IF I AM COVERED BY OTHER INSURANCE, I WILL FURNISH THE NECESSARY FORMS TO THIS OFFICE.

I HEREBY ASSIGN AND AUTHORIZE PAYMENT DIRECTLY TO ADVANCED INTERNAL MEDICINE, P.C. ANY MEDICAL AND SURGICAL BENEFITS OTHERWISE PAYABLE TO ME. SHOULD AN INSURANCE PAYMENT BE RECEIVED THAT IS LESS THAN THE PHYSICIAN'S USUAL CHARGE FOR THE SERVICES PROVIDED, I WILL BE RESPONSIBLE FOR THE DIFFERENCE. I UNDERSTAND IF MY INSURANCE PROVIDER DENIES PAYMENT FOR ANY SERVICE FOR ANY REASON I WILL BE RESPONSIBLE FOR THOSE CHARGES.

I ALSO AGREE TO PAY ALL COST OF COLLECTION INCLUDING, BUT NOT LIMITED TO REASONABLE ATTORNEY'S FEES, AND WAIVER ALL CLAIMS OF EXEMPTION UNDER THE LAW OF THE STATE OF ALABAMA.
FORM MUST BE SIGNED AND DATED BY PATIENT OR RESPONSIBLE PARTY.

DATE ______/______/______

X ________________________________
PATIENT AND/OR RESPONSIBLE PARTY