



HUNTSVILLE INTERNAL MEDICINE ASSOCIATES
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 (256) 881-1989

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PATIENT INFORMATION

PLEASE PRINT:

Date: _____

Patient's Name: _____ Referred By: _____

LAST FIRST MI

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

SSN ____ - ____ - ____ Sex: M F DOB: ____ / ____ / ____

Married ____ Divorced ____ Single ____ Widowed ____

Patient's Occupation: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____

Zip: _____ Employer's Phone: (____) _____

Spouse's Name: _____ Spouse's DOB: ____ / ____ / ____

Spouse's Occupation: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____

Zip: _____ Employer's Phone: (____) _____

Notify in Case of Emergency: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer's Phone: (____) _____

PRIMARY INSURANCE

Policy #	Group#
Insurer's Name:	Relationship to Patient
Insurer's SSN or ID #	
Insurance Company Name	

SECONDARY INSURANCE

2 ND Policy #	2 ND Group #
2 ND Insurer's Name:	2 ND Relationship to Patient
2 ND Insurer's SSN or ID #	
2 ND Insurance Company Name	

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____

Phone: (256) _____

Payment is required for all services at the time they are rendered. In the event of financial hardship, our office will attempt to negotiate a payment plan or file the appropriate insurance when hospitalization or major procedures are required. However, before such claims are filed, coverage will be pre-certified, and you will be asked to pay any unmet deductible, non-covered services and co-payments. Your signature below signifies your understanding and willingness to comply with this policy.

I authorize all physicians, medical professionals, hospitals and other medical care institutions, insurers, prepaid health plans, employers, group policy holders, contract holders, and benefit plan administrators to provide insurer with information concerning medical care, advice, treatment or supplies provided to the patient.

Signature: _____ **Date:** _____