

**PLEASE PRINT**



**St. Vincent's Orthopedics, P.C.**

|      |                |  |                                       |                                   |                                       |
|------|----------------|--|---------------------------------------|-----------------------------------|---------------------------------------|
| DATE | ACCOUNT NUMBER | REFERRED BY                              | <input type="checkbox"/> FRIEND _____ | <input type="checkbox"/> WEB SITE | <input type="checkbox"/> YELLOW PAGES |
|      |                | <input type="checkbox"/> PHYSICIAN _____ | <input type="checkbox"/> NEWSPAPER    | <input type="checkbox"/> MAGAZINE |                                       |

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

|                               |                                  |  |                                    |                                    |                |
|-------------------------------|----------------------------------|--|------------------------------------|------------------------------------|----------------|
| PATIENT'S FULL NAME           | SOC. SEC. NO.                    | <input type="checkbox"/> SINGLE <input type="checkbox"/> OTHER | <input type="checkbox"/> MALE      | DATE OF BIRTH                      | AGE            |
|                               |                                  | <input type="checkbox"/> MARRIED                               | <input type="checkbox"/> FEMALE    | / /                                |                |
| STREET ADDRESS                | CITY, STATE, ZIP CODE            |  |                                    | HOME PHONE                         |                |
| PATIENT'S EMPLOYER            | OCCUPATION (INDICATE IF STUDENT) |  | <input type="checkbox"/> PART TIME | <input type="checkbox"/> FULL TIME | BUSINESS PHONE |
| EMPLOYER'S STREET ADDRESS     | CITY, STATE, ZIP CODE            |  |                                    | CELL PHONE                         |                |
| SPOUSE'S OR PARENT'S NAME     | SPOUSE'S SOC. SEC. NO.           | DATE OF BIRTH  |                                    | HOME PHONE                         |                |
|                               |                                  | / /  |                                    |                                    |                |
| SPOUSE'S OR PARENT'S EMPLOYER | OCCUPATION (INDICATE IF STUDENT) |  | <input type="checkbox"/> PART TIME | <input type="checkbox"/> FULL TIME | BUSINESS PHONE |

**RESPONSIBLE PARTY INFORMATION**

|                              |                       |               |                         |
|------------------------------|-----------------------|---------------|-------------------------|
| NAME OF RESPONSIBLE PARTY    | SOC. SEC. NO.         | DATE OF BIRTH | HOME PHONE              |
|                              |                       | / /           |                         |
| STREET ADDRESS               | CITY, STATE, ZIP CODE |               | RELATIONSHIP TO PATIENT |
| RESPONSIBLE PARTY'S EMPLOYER | OCCUPATION            |               | BUSINESS PHONE          |
| EMPLOYER'S STREET ADDRESS    | CITY, STATE, ZIP CODE |               |                         |

**INSURANCE INFORMATION**

|  |                               |           |   |               |
|--|-------------------------------|-----------|---|---------------|
| NAME OF PRIMARY INSURANCE CO.                            | CONTRACT NO.                  | GROUP NO. | NAME OF INSURED (AS IT APPEARS ON YOUR INS. CARD) | DATE OF BIRTH |
|  |                               |           |   | / /           |
| NAME OF SECONDARY INSURANCE CO.                          | CONTRACT NO.                  | GROUP NO. | NAME OF INSURED (AS IT APPEARS ON YOUR INS. CARD) | DATE OF BIRTH |
|  |                               |           |   | / /           |
| ARE YOU INSURED UNDER YOUR SPOUSE'S INSURANCE?           | IF YES: NAME OF INSURANCE CO. |           | CONTRACT NO.                                      | GROUP NO.     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO |                               |           |   |               |
| CONTACT PERSON FOR WORKERS COMPENSATION                  | COMPANY                       | PHONE     |   |               |

**PLEASE PROVIDE FRONT DESK WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE**

**IN CASE OF EMERGENCY NOTIFY (OTHER THAN SHOWN ABOVE)**

|      |            |                |              |
|------|------------|----------------|--------------|
| NAME | HOME PHONE | BUSINESS PHONE | RELATIONSHIP |
|      |            |                |              |

**EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES**

I hereby authorize St. Vincent's Orthopedics, P.C. to furnish any information concerning my medical condition, treatment, and prognosis to my insurance carriers and other treatment physicians.

I hereby assign St. Vincent's Orthopedics, P.C. all payments for medical and/or surgical services rendered to me or my dependents due or received from third-party providers. I agree to be responsible for any amount not covered by my insurance or other providers. I agree to pay all costs of collection including a reasonable attorney's fee (should this account be placed with an attorney for collection), and interest on the unpaid balance at the rate of ten (10%) percent per annum. I hereby waive all rights of exemption under the U.S. and Alabama Constitutions and the laws of the State of Alabama.

I AUTHORIZE TREATMENT BY St. Vincent's Orthopedics, P.C.

DATE \_\_\_\_\_

X \_\_\_\_\_  
PATIENT AND/OR RESPONSIBLE PARTY