___ NEAL G. CLEMENT, M.D.
___ GILBERT R. MELSON, M.D.
___ A. E. JOINER, M.D.
___ JOHN A. YOUNG, M.D.

___ JEFFREY GOODMAN, M.D.
___ FRANK HATCHETT, JR., M.D.
___ LLOYD JOHNSON, III, M.D.
___ J. STEPHEN HOWELL, D.O.

NORTH ALABAMA BONE & JOINT CLINIC, P.C.

Date: ______________ **Patient ID:** ________________

SECTION 1 PATIENT INFORMATION

Last Name: ________________ First Name: ________________ Middle Name: __________

Age: ________ DOB: __________ Home Phone: ( ) ____________ Cell Phone: ( ) ______________

Marital Status: ☐ S ☐ M ☐ D ☐ W Sex: ☐ M ☐ F Social Security No. ________________

Address: ______________________ City: ______________ State: ______ Zip: __________

Occupation: ______________ Employer: ________________ Employer Phone: ( ) ______________

Employer's Address: ____________________ City: ____________ State: ______ Zip: ________

Emergency Contact Name: ______________ (Please list someone outside your home.) Phone Number: ( ) __________

SECTION 2 RESPONSIBLE PARTY (If Different From Patient)

Last Name: ________________ First Name: __________ Middle Initial: ______ SSN: ______________

Address: ______________________ City ______________ State: ______ Zip: __________

Home Phone: ( ) ____________ Cell Phone: ( ) ____________ Patient's Relation to Responsible Party: ________

Employer Name & Address: ______________________________ Employer Phone: ( ) __________

SECTION 3 PRIMARY INSURANCE SECONDARY INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE
Company: ____________________	Company: ____________________
Policy Number: ____________________	Policy Number: ____________________
Group Number: ____________________	Group Number: ____________________
Policy Holder's Name: ____________________	Policy Holder's Name: ____________________
Policy Holder's Place of Employment: ______________	Policy Holder's Place of Employment: ______________
Policy Holder's Date of Birth: ______________	Policy Holder's Date of Birth: ______________
Patient's Relationship to Policy Holder: ______________	Patient's Relationship to Policy Holder: ______________
Sex: M ☐ F ☐	Sex: M ☐ F ☐

SECTION 4

Were you referred by another Doctor? ☐ Yes ☐ No Doctor's Name: ______________________

Who is your Medical Doctor? Name: ______________________________

Please check one of the following: ☐ Work related Injury ☐ Personal Injury ☐ No Injury ☐ Automobile Accident

Date of Injury/ Onset : ____________________

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by North Alabama Bone & Joint Clinic, P.C. for the above named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier- a copy of the signature is as valid as the original.

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for North Alabama Bone & Joint Clinic, P.C. to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original.

Date: ________________ **Signature of Patient:** ______________________________

(If Minor, Signature of Responsible Party)