ALABAMA CARDIOLOGY, P.C.

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BOARD CERTIFIED IN CARDIOLOGY, NUCLEAR CARDIOLOGY, ECHOCARDIOGRAPHY AND INTERVENTIONAL CARDIOLOGY

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NEW PATIENT INFORMATION (PLEASE READ CAREFULLY. PRINT AND COMPLETE FORM IN FULL)

PATIENT'S NAME IN FULL (NO NICKNAMES)	DATE OF BIRTH	MARITAL STATUS	AGE	SEX	SSN

ADDRESS	CITY & STATE	ZIPCODE

HOME TELEPHONE #	CELL PHONE #	EMAIL

OCCUPATION	EMPLOYER	WORK #

EMERGENCY CONTACT	EMERGENCY CONTACT PHONE #	RELATIONSHIP TO PATIENT

HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH	SEX	PHONE #

EMPLOYER OF ABOVE NAME	OCCUPATION

REFERRED BY/ FAMILY DOCTOR	ADDRESS, CITY, STATE, ZIP	PHONE #

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	DOES YOUR INSURANCE REQUIRE PRIOR AUTHORIZATION FOR TREATMENT?

NAME OF POLICY HOLDER	DATE OF BIRTH	PHONE # TO CALL FOR AUTHORIZATION

POLICY NUMBER	GROUP NUMBER

ADDRESS OF INSURANCE COMPANY

SECONDARY INSURANCE COMPANY	ADDRESS OF INSURANCE COMPANY

NAME OF POLICY HOLDER	DATE OF BIRTH

POLICY NUMBER	GROUP NUMBER

PLEASE READ THE FOLLOWING: ALL BILLS ARE PAYABLE AT THE TIME SERVICES ARE RENDERED. ANY OTHER ARRANGEMENTS MUST BE MADE IN ADVANCE; INSURANCE IS FILED AS A COURTESY.

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE ABOVE PHYSICIAN/ SUPPLIER FOR SERVICES DESCRIBED.

SIGNATURE:

AUTHORIZATION TO RELEASE INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE: