



ALABAMA ORTHOPAEDIC SPECIALISTS, P.A.

Is this visit due to a sports injury? Yes ___ No ___

If yes, which school do you attend? _____

In which sport do you participate? _____

DATE _____

DRUG ALLERGIES _____

DRUG STORE _____

MARITAL STATUS ___M ___S ___D ___W

PLEASE PRINT

Patient Name _____ Sex ___M ___F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Social Security # _____ Date of Birth _____ Age _____

Employer _____ Occupation _____ Work Phone _____

Parent or Spouse Name _____ Address _____

Employer _____ Work Phone _____

Reason for Visit _____

Job Injury? ___ Motor Vehicle? ___ Other Accident? ___ Date of Accident? ___

Give Place and How The Accident Occurred _____

Name and phone # of nearest friend or relative not residing with you _____

Referred by _____ Name of Primary Doctor _____

MEDICAL INSURANCE INFORMATION

Name of Primary Ins. Co. _____ Group # _____ Policy # _____

Cardholders Name _____ Relationship to Cardholder _____

Name of Secondary Ins. Co. _____ Group # _____ Policy # _____

Cardholders Name _____ Relationship to Cardholder _____

Method of Payment ___Cash ___Check ___Credit Card ___Other

PLEASE READ BEFORE SIGNING

I/We, the undersigned, authorize and consent to the rendering of emergency care, including diagnostic procedures, and medical treatment, by A.O.S. physicians or authorized members of our staff, as may in their professional judgment be necessary for the above patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. Authorization is hereby given to release such information as may be necessary for the completion of my hospital/medical claims. I further agree to pay all medical expense incurred resulting from this treatment and authorization, and I assign any insurance benefits applicable. I waive any right which I may have according to the Constitution and Laws of Alabama, or any other state, to claim exemption as to personal property as to this obligation, and if this obligation is not paid in full when due, I agree to pay all costs of collecting it, including a reasonable attorney's fee. I understand and agree to pay Alabama Orthopaedic Specialists, P.A. for medical services and supplies provided that are not covered under PMD, MEDICARE, HMO, OR ANY OTHER PROGRAMS.

Signature of Patient or Legal Guardian _____ Date _____

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE.

Worker comp carrier _____ Company Name _____

Carrier Address _____ Company Address _____

City, State, Zip _____ City, State, Zip _____

Phone Number _____ Authorized By _____

Contact Person _____ Phone # and Ext. _____