ALABAMA ORTHOPAEDIC SPECIALISTS, P.A.

DATE ____________________

DRUG ALLERGIES ____________________

DRUG STORE ____________________

Is this visit due to a sports injury? Yes____ No____

If yes, which school do you attend? ____________

In which sport do you participate? ____________

PLEASE PRINT

Patient Name ____________________ Sex ________

Address ____________________ City ____________ State ____ Zip ________

Social Security# ____________ Date of Birth ________ Age ________ Marital Status __M __S __D __W

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Employer ____________ Occupation ____________ Employer Phone ________

Parent or Spouse Name ____________ Address ____________________

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 ________ 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 judgement 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 ____________________