Rheumatology Associates Of
North Alabama, P.C.
720 Gallatin Street, Suite 500
Huntsville, Alabama 35801

Date: _____

INITIALS	OFFICE USE ONLY
ACCOUNT NO.	

PATIENT'S NAME IN FULL (NO NICKNAMES) Last Name First	MARITAL (S M W D SEP)	DATE OF BIRTH	AGE	SEX

RACE: ❑ AFRICAN AMERICAN ❑ ASIAN ❑ CAUCASIAN / WHITE ❑ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER ❑ AMERICAN INDIAN / ALASKA NATIVE ❑ DECLINED ❑ UNKNOWN

PRIMARY LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ OTHER _____	ETHNICITY: ❑ HISPANIC ❑ NON-HISPANIC ❑ DECLINED ❑ UNKNOWN

ADDRESS	CITY , STATE & ZIP

SOCIAL SECURITY NO.	HOME PHONE NO. ( )	BUSINESS PHONE NO. ( )	CELL PHONE NO. ( )

OCCUPATION (INDICATE IF STUDENT)	EMPLOYER	HOW LONG EMPLOYED?	RELIGION (OPTIONAL)

EMPLOYERS ADDRESS	CITY, STATE & ZIP

HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH	SSN

EMPLOYER OF ABOVE NAME	CITY & STATE	ZIP CODE	BUSINESS PHONE NO. ( )

PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE	RELATIONSHIP	HOME TELEPHONE NO. ( )	BUSINESS PHONE NO. ( )

ADDRESS	CITY, STATE & ZIP

REFERRING PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )

FAMILY PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )

PERSON RESPONSIBLE FOR BILL: _____

IF OTHER THAN PARENT, S.S.# _____

ADDRESS OF RESPONSIBLE PARTY _____

PRIMARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY

CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:

SECONDARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY

CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:

OTHER INSURANCE	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY

CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by Rheumatology Associates of North Alabama, 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 is continuing while patient is under care of Rheumatology Associates of North AL, P.C. or until patient revokes authorization. **For Medicare patients only** - Medicare will not pay on the following: Schrimer Test and calcitonin injections.

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Rheumatology Associates of North Alabama, 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. Authorization is continuing while patient is under care of Rheumatology Associates of North Alabama, P.C. or until patient revokes authorization.

Signature: _____ Date: _____

SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD, VISA OR DISCOVER