

**Rheumatology Associates Of
North Alabama, P.C.**

4606 Bellewood Dr. SE
Huntsville, Alabama 35802

Date: _____

INITIALS	OFFICE USE ONLY
ACCOUNT NO.	

PATIENT'S NAME IN FULL (NO NICKNAMES) Last Name First					MARITAL					DATE OF BIRTH	AGE	SEX
					S	M	W	D	SEP			
RACE: <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> CAUCASIAN / WHITE <input type="checkbox"/> NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN / ALASKA NATIVE <input type="checkbox"/> DECLINED <input type="checkbox"/> UNKNOWN												
PRIMARY LANGUAGE:						ETHNICITY:						
<input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER _____						<input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> DECLINED <input type="checkbox"/> UNKNOWN						
ADDRESS						CITY, STATE & ZIP						
SOCIAL SECURITY NO.				CELL NO. ()		HOME NO. ()			EMAIL			
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		CELL NO. ()			HOME 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: Schirmer 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