MEDICAL ASSOCIATES OF THE SHOALS, PC

PATIENT DEMOGRAPHICS

WHEN REGISTERING, PLEASE PRESENT PROOF OF INSURANCE. ALL COPAYMENTS AND OUT OF POCKET PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	SPOUSE'S NAME
			- -	/ /	M F	S M W D	

ADDRESS	CITY	STATE	ZIP	HOME PHONE
				( ) -

EMAIL	PREFERRED PHARMACY	CELL PHONE
		( ) -

PREFERRED METHOD OF COMMUNICATION: HOME PHONE ☐ CELL PHONE ☐ MAIL ☐ EMAIL ☐ **WORK PHONE** ( ) -

RACE: WHITE (CAUCASION) ☐ BLACK (AFRICAN AMERICAN) ☐ AMERICAN INDIAN ☐ ASIAN ☐ OTHER ☐ I DECLINE TO LIST RACE ☐

PRIMARY LANGUAGE: ENGLISH ☐ OTHER ☐ **OCCUPATION (*PATIENT*):**

INSURANCE #1 (PRIMARY INSURANCE - THIS WILL BE FILED FIRST)

INSURANCE COMPANY	CONTRACT NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE

SUBSCRIBER'S LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
			- -	/ /	M F	S M W D	

ADDRESS	CITY	STATE	ZIP

EMPLOYER	ADDRESS

INSURANCE #2 (SECONDARY INSURANCE - THIS WILL BE FILED AFTER PRIMARY INSURANCE PAYS)

INSURANCE COMPANY	CONTRACT NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE

SUBSCRIBER'S LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
			- -	/ /	M F	S M W D	

ADDRESS	CITY	STATE	ZIP

EMPLOYER	ADDRESS

EMERGENCY CONTACT INFORMATION

LAST NAME	FIRST NAME	HOME PHONE	CELL PHONE	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP

FINANCIALLY RESPONSIBLE PARTY

THIS IS THE PERSON WHO ACCEPTS RESPONSIBILITY FOR PAYMENT OF THE ACCOUNT. THIS MAY OR MAY NOT BE THE SAME PERSON THAT HOLDS THE INSURANCE CONTRACT. ALL BILLING WILL GO TO THE FINANCIALLY RESPONSIBLE PERSON, AND THIS FORM MUST BE SIGNED BY THE PERSON WHO IS FINANCIALLY RESPONSIBLE.

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
			- -	/ /	M F	S M W D	

ADDRESS	CITY	STATE	ZIP

EMPLOYER	EMPLOYER PHONE NUMBER	ADDRESS

Insurance is a contract between you and your insurance company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-insurances, non-covered charges, pre-existing conditions, coordination of benefits, secondary insurance, or "reasonable and customary" charges, however, we will assist by filing your primary insurance and secondary insurance as a courtesy.

* **I understand and realize that failure to make timely payment and maintain financial compliance is a basis for legal action and any court cost / collection fees / attorney fees will be assumed by me.**

* **I have read the financial policy and understand I am personally responsible for payment on this account in the event that my insurance deems a service to be "non-covered".**

Signature - Financially Responsible (Guarantor)

Date