Account # _____

NORTHEAST ALABAMA SURGICAL ASSOCIATES / URQUHART PLASTIC SURGERY

Last Name:_____ **First Name:**_____ **MI:**_____

Gender (circle one): M F **Date of Birth:**_____ **SSN:**_____

Email Address:_____

Responsible Party:_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Referring Doctor:_____

Marital Status (circle one): Single Married Widowed Divorced Legally Separated **Race:**_____

Employment (circle one): Full-time Part-time Unemployed Self Retired Active Duty Unknown

Patient Employer:_____ **Occupation:**_____

Student Status (circle one): Full-time Part-time **If a student, Parent's Name:**_____

Spouse's Name:_____ **Spouse's Employer:**_____

Primary Insurance:_____

Subscriber's Last Name:_____ **First Name:**_____ **MI:**_____

Subscriber's DOB:_____ **SSN:**_____ **Gender:** M F

Patient's Relationship to the Subscriber:_____

Effective Date:_____ **Contract #:**_____ **Group #:**_____

Coverage Type (circle one): Group Auto Commercial HMO Individual Medicare Medicaid Other

If Medicare: Do you or your spouse still work?_____ Are you disabled?_____ Black Lung Benefits?_____

Secondary Insurance:_____

Subscriber's Last Name:_____ **First Name:**_____ **MI:**_____

Subscriber's DOB:_____ **SSN:**_____ **Gender:** M F

Patient's Relationship to the Subscriber:_____

Effective Date:_____ **Contract #:**_____ **Group #:**_____

Coverage Type (circle one): Group Auto Commercial HMO Individual Medicare Medicaid Other

If Medicare: Do you or your spouse still work?_____ Are you disabled?_____ Black Lung Benefits?_____

Tertiary Insurance:_____

Subscriber's Last Name:_____ **First Name:**_____ **MI:**_____

Subscriber's DOB:_____ **SSN:**_____ **Gender:** M F

Patient's Relationship to the Subscriber:_____

Effective Date:_____ **Contract #:**_____ **Group #:**_____

Coverage Type (circle one): Group Auto Commercial HMO Individual Medicare Medicaid Other

If Medicare: Do you or your spouse still work?_____ Are you disabled?_____ Black Lung Benefits?_____

Emergency Contact:_____ **Relationship to patient:**_____

Address:_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

***Allergies:**_____

***List all current medications:**_____

_____

_____

_____

Pharmacy:_____ **Pharmacy Phone #:**_____

Account # _____

NORTHEAST ALABAMA SURGICAL ASSOCIATES / URQUHART PLASTIC SURGERY
PATIENT REGISTRATION FORM

Assignment of Benefits

I hereby instruct and direct the aforementioned Insurance Company/Companies to pay the check made out to and mailed to:

The Surgical Clinic of Anniston, PA
McClellan Park Medical Mall
171 Town Center Drive
PO Box 5430
Anniston, AL 36205

For the professional and or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY

This payment will not exceed my indebtedness to the aforementioned assignee, and I have agreed to pay, in current manner, any balance of said professional service charges over and above the insurance payment as directed by my contract with my Insurance Company/Companies.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the aforementioned doctors to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

In the event of payment default, I agree to be responsible for all costs of collections, including, but not limited to: attorney fees, collection agency fees, and other related costs.

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____