

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 #: \_\_\_\_\_

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: \_\_\_\_\_