Anniston Orthopaedic Associates, P.A. (AOA)

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Patient Information Sheet

Date ________________________

Patient Demographics

Name:	Social Security Numbers:	Date of Birth:
Street Address:	City, State, and Zip Code:	Mailing Address:
Gender:	Race:	Ethnicity: Hispanic or Latino Not Hispanic or Latino
Marital Status:	Email Address:	Employment Status:
Employer Name:	Work Phone Number:	Home Phone Number:
Cell Phone Number:		

Emergency Contact

Emergency Contact Name:	Emergency Contact Relationship:	Emergency Contact Phone Number:

Primary Insurance Information

Primary Insurance Provider:	Policy Holder's Name:
Relationship to Policy Holder:	Policy Holder's Social Security Number:
Policy ID Numbers:	Policy Group Number:
Policy Holder's Date of Birth:	Policy Holder's Gender:

Secondary Insurance Information

Secondary Insurance Provider:	Policy Holder's Name:
Relationship to Policy Holder:	Policy Holder's Social Security Number:
Policy ID Number:	Policy Group Number:
Policy Holder's Date of Birth:	Policy Holder's Gender:

BLANKET AUTHORIZATIONS: I understand that the following authorizations are to be used by (AOA) and ALL PHYSICIANS associated herewith to effect the collection of benefits in my behalf. These authorizations become effective on the date of the first service rendered in my behalf. Copies of this Agreement will be as valid as this original.

BLANKET AUTHORIZATIONS TO RELEASE INFORMATION: I hereby authorize (AOA) and all physicians associated therewith, to release information related to all treatments and care.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize (AOA) and to physicians associated therewith, of the benefits payable under all plans of health insurance otherwise payable to me. I further understand that I am financially responsible for payment of charges not covered by this authorization.

LEGAL/COLLECTION FEE: I agree to pay ALL reasonable fees of attorneys and/or collection agencies needed to effect collection of any delinquent charges outstanding on my account. I (we) hereby agree to waive all personal property exemption rights under the laws of the State of Alabama.

NON-COVERED SERVICES: I understand that I will be billed directly by (AOA) for services rendered that my insurance carrier deems not medically necessary or non-covered services. These services may not be covered by third-party payers and I will be directly responsible for their payment. This includes co-pays and annual deductibles.

Patient's Signature: ______________________________ Date: ______________________________