TRINITY
FAMILY MEDICINE
at Liberty Park

Patient Name: Last ______ First ______ Middle ______

Address: ______

City: ______ State: ______ Zip: ______ Phone: ______

Sex: ______ Race: ______ Marital Status: ______ Birthdate: ______

Retired: ______ Employed: ______ Full time student: ______ Part time student: ______

Employer: ______ Phone: ______

Social Security: ______ Drivers License: ______

Person responsible for account: ______ Relationship: ______

Address: ______

City: ______ State: ______ Zip: ______ Phone: ______

Employer: ______ Phone: ______

Social Security: ______ Drivers License: ______

Spouse's Name: ______ Employer: ______ Phone: ______

Person to notify in case of emergency: ______ (Outside Your Home) Phone: ______ (Other Than Your Number)

Relatives or friends that are patients: ______

Drug Allergies: ______

Major Medical Problems:: ______

Have you arranged for a Living Will? (Advanced Directives) ☐ Yes ☐ No Have you appointed a durable power of attorney? ☐ Yes ☐ No

INSURANCE POLICY INFORMATION

Insurance Company (Primary): ______

Policy holder's name: ______ Birthdate: ______ / ______ / ______

Employer: ______

Contract or group: ______

Relationship of patient to policy holder: ______

Insurance Company (Secondary): ______

Policy holder's name: ______ Birthdate: ______ / ______ / ______

Employer: ______

Contract or group: ______

Relationship of patient to policy holder:

Referred by: ______

CONSENT FOR TREATMENT: - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize Trinity Family Medicine to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to Trinity Family Medicine of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Trinity Family Medicine charges for these services. I understand that I am financially responsible to Trinity Family Medicine for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by Trinity Family Medicine, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

SIGNATURE: ______ DATE: ______