

# Whitesburg Family Medicine

4704 Whitesburg Drive, Suite 201, Huntsville, AL, 35802. 256.327.0888  
Elisa J. Haley, MD David A. McMillion, MD

## Patient Registration

Name:	_____	Referred Here By:	_____				
Address:	_____	City:	_____	State:	_____	Zip:	_____
Home Phone:	_____	Cell:	_____	Sex:	_____	DOB:	_____
Age:	_____	SSN:	_____	Drivers Lic. #:	_____	Marital Status:	_____
Employer:	_____	Occupation:	_____	Work Phone:	_____		
Employer Address:	_____	Date of Employment:	_____				
Spouses Name:	_____	Spouses Employer:	_____				
Spouses Occupation:	_____	Spouses Work Phone:	_____				
Emergency Contact:	_____	Relation:	_____	Phone:	_____		

### PRIMARY INSURANCE INFORMATION

Name: \_\_\_\_\_

Group# \_\_\_\_\_ Contract#: \_\_\_\_\_ Co-pay \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Name: \_\_\_\_\_

Group# \_\_\_\_\_ Contract#: \_\_\_\_\_ Co-pay \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Whitesburg Family Medicine to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to the party who accepts assignment. I certify that the information I have reported with regard to the patient's insurance coverage is correct. I hereby acknowledge that I accept legal responsibility for all changes in connection with medical care provided by Whitesburg Family Medicine to myself, my minor child or as guardian of the above patient. I understand that my insurance company may not reimburse all of my charges incurred and I am responsible for all charges not satisfied in full by my insurance except where liability is limited by contract or State / Federal law. I will also be responsible for the cost of collection fees should my account be turned over to a collection agency.

Signed \_\_\_\_\_ Date: \_\_\_\_\_