



SOUTH ALABAMA ORTHOPEDICS & SPORTS MEDICINE, P.C.
DAVID A. CLARK, D.O.
 2126 West Roy Parker Road, Ste 201, Ozark, Alabama 36360

PATIENT INFORMATION

Home Phone _____

Patient _____ SSN _____
 Last First Middle

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Sex M F Age _____ Date of Birth _____ Single Married Divorced Widowed Separated

Patient Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Employer _____ Phone # _____

Emergency Contact _____ Phone _____

INSURANCE INFORMATION : If you have insurance, please provide us with a copy of all cards and a picture ID. If you do not have insurance, you will be responsible for your bill and payment is expected at the time of your visit. ALL COPAYS ARE PAYABLE AT THE TIME OF YOUR OFFICE VISIT

Primary Insurance _____

Cardholder's Name _____ SSN _____

Policy # _____ Cardholder's DOB _____

Secondary Insurance _____

Cardholder's Name _____ SSN _____

Policy # _____ Cardholder's DOB _____

ASSIGNMENT AND RELEASE

I, the undersigned, assign all applicable medical insurance benefits directly to South Alabama Orthopedics. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am fully responsible for all collection costs and/or Attorney Fees if my account is placed with a collection agency. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I request the payment of authorized Medicare benefits to be made on my behalf to South Alabama Orthopedics for services or supplies furnished to me. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____