SOUTHERN BONE & JOINT SPECIALISTS

1500 ROSS CLARK CIRCLE DOTHAN, AL / 4300 WEST MAIN STREET, SUITE 14 DOTHAN, AL
404 NORTH MAIN STREET, ENTERPRISE, AL

PLEASE PRINT

Payment due at time of services.

PATIENT INFORMATION			**USE OR (IF PATIENT IS A MINOR) FATHER'S INFORMA**	
LAST NAME	FIRST	MID. INITIAL	NAME	
ADDRESS			ADDRESS	
CITY	STATE	ZIP CODE	CITY STATE	ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	HOME PHONE	WORK PHONE
SEX M F	AGE	BIRTH DATE	RELATIONSHIP TO PT.	CELL PHONE
SOCIAL SECURITY NUMBER		MARITAL STATUS M S D W	SOCIAL SECURITY NO.	BIRTH DATE
EMPLOYER OR SCHOOL		OCCUPATION	EMPLOYER	
EMERGENCY CONTACT		PHONE	OCCUPATION	

MOTHER'S INFORMATON (IF PATIENT IS A MINOR)			
NAME		SOCIAL SECURITY NO.	BIRTH DATE
ADDRESS		EMPLOYER	
CITY	STATE ZIP CODE	OCCUPATION	
HOME PHONE	WORK PHONE	CELL PHONE	

REASON FOR APPOINTMENT

DESCRIBE SYMPTOM / PROBLEM & WHEN IT BEGAN

PLEASE LIST THE NAME OF THE REFERRING PHYSICIAN

ACCIDENT INFORMATION (IF NOT AN ACCIDENT SKIP TO NEXT SECTION)

IS THIS PROBLEM DUE TO AN AC ACCIDENT DATE:	TYPE OF ACCIDENT: ON THE JOB AUTO
ACCIDENT OCCURRED IN STATE OF:	IF YOU HAVE AN ATTORNEY, LIST THEIR NAME & NUM
IF AUTO ACCIDENT, LIST AUTO INSURANCE INFORMATION BELOW	
	IF ON THE JOB INJURY, LIST WORKERS COMP INFOR

LIST IMMEDIATE FAMILY MEMBERS WHO ARE PATIENTS OF SBJS BELOW

NAME(S) & DATE(S) OF BIRTH

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
SUBSCRIBER & RELATION TO PATIENT	SUBSCRIBER & RELATION TO PATIENT
POLICY # / GROUP #	POLICY # / GROUP #

RELEASE, ASSIGNMENT, AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize release
injury is job-related, school officials if injury is school-related, insurance companies, third party administrators or payor
patient or duly authorized general agent of the patient authorized to furnish the information requested. I agree to the it
per month (18% PER ANNUM), (2) I agree and hereby consent that I will be responsible for reasonable collection cost
Southern Bone and Joint Specialists, in the collection of same, whether such outstanding balance is satisfied prior to,
lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and costs thereon, shall be limit
defenses and/or objections to said jurisdiction. By signing below, I consent to the terms contained herein and affirmati
provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waiv
of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy I understa
& Joint Specialists Financial Policies.

SIGNATURE OF PATIENT/GUARDIAN AND/OR AUTHORIZED AGENT _____ DATE _____