Welcome To Our Office

Vincent Bergquist Jr. M.D
Don Hirsbrunner M.D.

DATE: _______________ AGE: ________

PATIENT INFORMATION

NAME	SOCIAL SECURITY NUMBER	MARITAL STATUS **S M D W SEP**	SEX	RACE	DATE OF BIRTH
ADDRESS	CITY, STATE	ZIP CODE	HOME TELEPHONE NUMBER		
CELL PHONE NUMBER	EMAIL ADDRESS				
EMPLOYER	EMPLOYER CITY AND ZIP CODE	EMPLOYER PHONE NUMBER			
PHARMACY NAME	PHARMACY NUMBER	PHARMACY CITY			
EMERGENCY CONTACT (NOT LIVING WITH YOU)	RELATIONSHIP	EMERGENCY CONTACT PHONE NUMBER			

IF MINOR: COMPLETE THIS SECTION

NAME OF SCHOOL

FATHER'S NAME	EMPLOYER	SOCIAL SECURITY NUMBER	DOB	TELEPHONE NUMBER
MOTHER'S NAME	EMPLOYER	SOCIAL SECURITY NUMBER	DOB	TELEPHONE NUMBER

PLEASE READ: CO-PAYMENT ON OFFICE VISIT DUE TODAY.

PERSON RESPONSIBLE FOR PAYMENT	ADDRESS, CITY, STATE		ZIP CODE
TELEPHONE CONTACT NUMBERS (HOME)	(CELL)		(WORK)
PRIMARY INSURANCE	CONTRACT NUMBER	GROUP	POLICY HOLDER'S DATE OF BIRTH
POLICY HOLDER'S NAME	POLICY HOLDER'S EMPLOYER		POLICY HOLDER'S EMPLOYER TELEPHONE
SECONDARY INSURANCE	CONTRACT NUMBER	GROUP	POLICY HOLDER'S DATE OF BIRTH
POLICY HOLDER'S NAME	POLICY HOLDER'S EMPLOYER		POLICY HOLDER'S EMPLOYER TELEPHONE
INJURY: WHERE WERE YOU INJURED:	□ WORK □ AUTO	□ HOME □ OTHER	□ ILLNESS
DATE OF ACCIDENT OR INJURY:			

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also agree to pay costs of collections, including attorney's fees and waive my exemption under the constitution and laws of the state of Alabama. I herby authorize Orthopedic & Sports Medicine Specialists of Cullman to furnish information to insurance carriers and referring physicians concerning my illness and treatments.

SIGNATURE: ____ DATE: ___________________________