



Patient Information

Last Name		First		Middle				
Your Billing Address			City	State	Zip			
Street Address			City	State	Zip			
Birthdate		Occupation			Primary Physician			
Employer				Employer's Address				
Home Telephone #		Work Telephone #		Cell Phone #	Email Address			
Married	Divorced	Single	Widowed	Social Security #	Driver's License #	State	Sex M / F	Age
Emergency Contact (outside of the home)				Phone Number				

Insurance Information

Name of Insurance Company			Policy Number			
Group Number		Effective Date		Subscriber's Name		Relationship/DOB
Additional Insurance			Policy Number			
Group Number		Effective Date		Subscriber's Name		Relationship/DOB
Primary Care Physician with Insurance Carrier						

Insured / Spouse / Parent

Name		Birthdate		Social Security Number	
Employer				Work Telephone Number	
Employer's Address					

I hereby authorize CULLMAN REGIONAL GYNECOLOGY CLINIC to furnish to the insurance company(s) on file or to a designated attorney, all information which said insurance company(s) or attorney may request. I hereby assign to CULLMAN REGIONAL GYNECOLOGY CLINIC all money to which I am entitled for medical and/or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from insurance company(s) on file, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor(s) for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and responsible legal fees should this be required. I understand that it is my responsibility to furnish current and correct personal and insurance information to CULLMAN REGIONAL GYNECOLOGY CLINIC in a timely manner.

Insured or Guardian Signature

Patient's Signature

Date