CULLMAN REGIONAL
Family Care

Cullman Regional Family Care Clinic
1948 Alabama Highway 157
Professional Office Building 1
Suite 450
(256) 735-5075

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		

Would you like to enroll in our Patient Portal? Yes_____ No_____

I hereby authorize CULLMAN REGIONAL FAMILY CARE 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 FAMILY CARE 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 FAMILY CARE CLINIC in a timely manner.

Insured or Guardian Signature _____ Patient's Signature _____ Date _____