



- Dr. J. Michael Straughn
- Dr. Charles Wingard
- Dr. William Somerall
- Dr. Ashley Tamucci
- Dr. Heidi Straughn

# PATIENT REGISTRATION

**Please fill out COMPLETELY.**  
This aids us in Billing, but more importantly in keeping in contact with you regarding your health.

CHART NO. \_\_\_\_\_

**PLEASE PRINT**

NAME \_\_\_\_\_ SS# \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ RACE \_\_\_\_\_ RELIGION \_\_\_\_\_

MARITAL STATUS:    M    S    D    W    REFERRED BY \_\_\_\_\_

PATIENT'S EMPLOYER \_\_\_\_\_ POSITION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

HUSBAND'S NAME \_\_\_\_\_ HUSBAND'S SS # \_\_\_\_\_

HUSBAND'S EMPLOYER \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_ HUSBAND'S DATE OF BIRTH \_\_\_\_\_

NAME OF NEAREST RELATIVE OR FRIEND (Excluding husband) **NOT LIVING AT YOUR ADDRESS:**

\_\_\_\_\_ / RELATIONSHIP \_\_\_\_\_

PHONE # \_\_\_\_\_

(1) NAME OF **PRIMARY** INSURANCE COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_ CONTRACT # \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_ POLICY HOLDER'S DATE OF BIRTH \_\_\_\_\_

POLICY HOLDER'S EMPLOYER \_\_\_\_\_

(2) NAME OF **SECONDARY** INSURANCE COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_ CONTRACT # \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_ POLICY HOLDER'S DATE OF BIRTH \_\_\_\_\_

POLICY HOLDER'S EMPLOYER \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to my insurance company.

I HEREBY ASSIGN TO AND AUTHORIZE DIRECTLY TO THE ABOVE PHYSICIAN ALL BENEFITS PAYABLE UNDER THE TERMS OF ANY INSURANCE POLICY LISTED ABOVE. I REALIZE THE INSURANCE MAY NOT PAY ALL OF THE BILL. I AGREE TO PAY THE DIFFERENCE OF THE ENTIRE BILL IF NECESSARY. I ALSO AGREE TO PAY COSTS OF COLLECTION, INCLUDING ATTORNEY'S FEE AND WAIVE MY EXEMPTION UNDER THE CONSTITUTION AND LAWS OF THE STATE OF ALABAMA.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE