



# MIDDLE CREEK MEDICAL CENTER

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Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

## PATIENT INFORMATION

Patient Name: Last: \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Retired \_\_\_\_\_ Employed \_\_\_\_\_ Full Time student \_\_\_\_\_ Part time student \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Driver's License: \_\_\_\_\_

Person responsible for account \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Driver's License: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

(Outside Your Home)

(Other Than Your Number)

Relatives or friends that are patients: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Present Medications: \_\_\_\_\_

Major Medical Problems: \_\_\_\_\_

### If patient is a minor, we must have the following information:

Parent's Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Telephone: \_\_\_\_\_

**OVER**

**INSURANCE POLICY INFORMATION**

Insurance Company (Primary): \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Contract and Group Number: \_\_\_\_\_

Relationship of patient to policy holder: \_\_\_\_\_

Insurance Company (Secondary): \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Contract and Group Number: \_\_\_\_\_

Relationship of patient to policy holder: \_\_\_\_\_

Referred by: \_\_\_\_\_

CONSENT FOR TREATMENT - I consent to necessary treatment, including drugs, medicine, procedures, x-rays, lab tests and / or other studies that may be used by the physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I understand that my medical information may be given to the insurance company with whom I have coverage, agencies which may be assisting with payment for my care, billing agencies, agencies responsible for reviewing payments and / or quality of care, and other governmental agencies. I give permission for the release of this information.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to Middle Creek Medical Center of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Middle Creek Medical Center charges for these services. I understand that I am financially responsible to Middle Creek Medical Center for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by Middle Creek Medical Center I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_