BBSMD, PC
Demographic Information

Patient **Date:_____**

First Name:_____Middle Name:_____Last Name:_____
Birth Date:_____ SSN_____ Gender_____ Race_____
Address:_____City:_____ State:_____Zip Code:_____
Home Phone _____ Work Phone_____ Cell Phone_____
Primary Language_____Mother's Maiden Name_____Medication Allergies_____

Responsible Party Information

Mother's First Name_____ Middle Name_____ Last Name_____
Birth Date:_____ SSN_____ Gender_____ Race_____Marital Status_____
Address:_____City:_____ State:_____Zip Code:_____
Home Phone _____ Work Phone_____ Cell Phone_____
Employment_____Phone Number_____
Employment Address_____City_____State_____Zip Code_____

Father's First Name_____ Middle Name_____ Last Name_____
Birth Date:_____ SSN_____ Gender_____ Race_____Marital Status_____
Address:_____City:_____ State:_____Zip Code:_____
Home Phone _____ Work Phone_____ Cell Phone_____
Employment_____Phone Number_____
Employment Address_____City_____State_____Zip Code_____

In Case of an Emergency Notify (List Two People Other Than Responsible Party)

First Name_____Middle Name_____Last Name_____
Address_____City_____State_____Zip Code_____
Home Phone_____Work Phone_____Cell Phone_____

First Name_____Middle Name_____Last Name_____
Address_____City_____State_____Zip Code_____
Home Phone_____Work Phone_____Cell Phone_____

Insurance Information

Primary Insurance_____Policy Number_____Group Number_____
Address_____City_____State_____Zip Code_____
Name on Card_____Effective Date_____Copay Amount_____
Subscriber Date of Birth_____Place of Employment_____

Secondary Insurance_____Policy Number_____Group Number_____
Address_____City_____State_____Zip Code_____
Name on Card_____Effective Date_____Copay Amount_____
Subscriber Date of Birth_____Place of Employment_____

Pharmacy Name_____

Patient Name:_____Date of Birth:_____

Explanation of Payment Policy and Insurance Filing Procedures

I hereby authorize BBSMD, PC to release any and all information acquired in my examination and treatment to my insurer listed above. I will furnish my insurance card for your information.
I hereby assign and authorize payment directly to BBSMD, PC any medical and surgical benefits otherwise payable to me. Should an insurance payment be received that is less than the physician's usual charge for the service provided, I will be responsible for the difference.
I freely give my permission for the physicians or nurses of BBSMD, PC to perform the needed procedure or examination on my child whose name is noted above. I also agree to be responsible for any and all charges incurred by the performance of any procedure(s) or examination.
I understand that my insurance may or may not pay for the procedure(s) or examination, and that I will be required to pay part or all of the charges incurred.
I also agree to pay all cost of collection including, but not limited to reasonable attorney's fees, and waiver all claims of exemption under the Law of The State of Alabama.

Form must be signed and dated by Parent or Responsible Party.

Date_____/_____/_____ _____

Parent or Responsible Party