



PATIENT REGISTRATION INFORMATION
OB/GYN ASSOCIATES OF ALABAMA, P.C.

800 St. Vincent's Drive, Suite 600
Birmingham, Alabama 35205

John C. Foster, M.D.
William M. Johnson, III, M.D.

(PLEASE PRINT)

Rupa D. Goolsby, M.D.
Jodie B. Benton, M.D.

WELCOME TO OUR OFFICE!

DATE: \_\_\_\_\_

Name Last First Middle Account Number

Street Address City, State, Zip Code

Employer Name and Address Marital Status M S D W
( ) ( ) ( )

Home Telephone Work Telephone Emergency Telephone # & Relationship to Patient
( )

Date of Birth Social Security # Husband's Name Husband's Daytime Telephone

Responsible Party Relationship To Patient

Street Address City, State, Zip Code

Responsible Party Employer Telephone Responsible Party Date of Birth

Responsible Party Social Security Number

PRIMARY INSURANCE PRIMARY POLICY # GROUP POLICY # COPAY 1

SECONDARY INSURANCE SECONDARY POLICY # GROUP POLICY # COPAY 2

PRIMARY DOCTOR'S NAME REFERRING PHYSICIAN NAME

DRIVERS LICENSE # E-MAIL ADDRESS

HOW DID YOU HEAR ABOUT OUR PRACTICE? [ ] PHYSICIAN [ ] NEWSLETTER [ ] WELCOME BOOKLET [ ] OTHER [ ] FRIEND

MAY WE HAVE THEIR NAME SO WE CAN SEND A THANK YOU? \_\_\_\_\_

CONSENT FOR TREATMENT - I CONSENT TO NECESSARY TREATMENT, INCLUDING DRUGS, MEDICINE, PERFORMANCE OF OPERATIONS AND CONDUCT OF X-RAY, OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING PHYSICIAN, HIS NURSE OR STAFF.

AUTHORIZATION FOR RELEASE OF INFORMATION - I AUTHORIZE OG/GYN ASSOCIATES OF ALABAMA, P.C. TO FURNISH ANY MEDICAL INFORMATION REQUESTED BY INSURANCE COMPANIES WITH WHOM I HAVE COVERAGE, ANY PUBLIC AGENCY WHICH MAY BE ASSISTING IN PAYMENT OF MY CARE, OR MY EMPLOYER WHO IS PROVIDING PAYMENT OF MY MEDICAL BILLS, DUE TO AN ON THE JOB INJURY.

ASSIGNMENT OF BENEFITS - I HEREBY AUTHORIZE PAYMENT DIRECTLY TO OB/GYN ASSOCIATES OF ALABAMA, P.C., OF BENEFITS OTHERWISE PAYABLE TO ME INCLUDING MAJOR MEDICAL INSURANCE AND PAYMENT OF SURGICAL OR MEDICAL BENEFITS, BUT NOT TO EXCEED THE OB/GYN ASSOCIATES OF AL, P.C., CHARGES FOR THESE SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO OB/GYN ASSOCIATES OF ALABAMA, P.C. 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 OB/GYN ASSOCIATES OF ALABAMA, P.C. I HEREBY GURANTEE 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: \_\_\_\_\_