

RUSSELLVILLE MUSCULOSKELETAL CENTER
 Said G. Osman, MD, F.R.C.S.Ed, F.R.C.S.Ed (ortho)
 15225 Hwy 43 S, Suite 1, Russellville, AL 35653

PATIENT REGISTRATION - Please Print Clearly

PATIENT NAME First Middle Last			DATE OF BIRTH		AGE
HOME ADDRESS		APT. NO.	CITY		STATE ZIP
OCCUPATION	SOCIAL SECURITY NO.	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		SEX <input type="checkbox"/> M <input type="checkbox"/> F	HOME PHONE
EMPLOYER	ADDRESS			WORK PHONE	
SPOUSE'S NAME (OR PARENT)	SPOUSE'S EMPLOYER (OR PARENT)			SPOUSE'S WORK PHONE (OR PARENT)	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	WORK PHONE		HOME PHONE	
REFERRED BY	FAMILY DOCTOR			DATE OF INJURY/ILLNESS	

BILLING AND INSURANCE INFORMATION

CHECK ONE: PERSONAL INJURY WORKER'S COMPENSATION AUTO INVOLVED INJURY

SEND BILL TO	FIRST NAME	LAST NAME		RELATIONSHIP TO PATIENT		
	HOME ADDRESS		CITY	STATE		
	EMPLOYER		WORK PHONE	HOME PHONE		
PRIMARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP/CODE		
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY		DATE EFFECTIVE	
	SUBSCRIBER'S NAME		SEX	HOME PHONE	RELATIONSHIP TO PATIENT	
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH		
SECONDARY INSURANCE	INSURANCE COMPANY NAME		IS THIS THROUGH EMPLOYER <input type="checkbox"/> OR INDIVIDUAL <input type="checkbox"/>		ID OR POLICY NUMBER GROUP/CODE	
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY		DATE EFFECTIVE	
	SUBSCRIBER'S NAME		SEX	HOME PHONE	RELATIONSHIP TO PATIENT	
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH		

The undersigned agrees to promptly pay all charges when billed for medical services rendered and the persons listed below agree and do hereby become legally responsible for any and all charges incurred for the patient named above. I understand that my medical bill is a matter between myself and my insurance company. Any unpaid balances are due within 30 days of treatment. I understand that I will be responsible for any collection or court costs should my account be turned over to collections.

SIGNATURE

PATIENT AUTHORIZATION

I, _____ hereby authorize Russellville Musculoskeletal Center to apply for benefits on my behalf for covered services rendered by the above physician, and request that payments from Blue Cross/Blue Shield of Alabama/Medicare and/or _____ be made directly to the above physician (or in case of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including medical information of this or any related claim, to the above named billing agent. Blue Shield of Alabama (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration.)/Medicare and/or _____. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or Blue Cross or Blue Shield of Alabama at any time in writing.