



MedCenter North
3909 McFarland Boulevard
Northport, Alabama 35476
Phone: (205) 333-1993 Fax: (205) 333-0293

Robert Posey, M.D.
Perry Lovely, M.D.
Chris McGee, M.D.
Michael McIntyre, MD

David Fernandez, MD
Alisa Johnson, MD
Lisa Ryan, CRNP
Dimple Thakor, CRNP

Date: ___/___/___
Age: _____

Who is your primary care physician? _____

PATIENT INFORMATION

Patient Name: Last: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____ Birthdate: _____

Home Phone Number: _____ Cell Number: _____ Sex: ___ Race: ___ Marital Status: ___

Employer: _____ Phone: _____

Social Security Number: _____ Driver's License: _____

Person responsible for account: _____ Relationship: _____

Person to notify in case of emergency: _____ Phone: _____

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

Parent's Name: _____ Social Security: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

Drug Allergies: _____

Present Medication: _____

Major Medical Problems: _____

CONSENT FOR TREATMENT - I consent to necessary treatment, including drugs, medicine, 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 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 to this information.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to MedCenter North, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the MedCenter North, P.C. charges for these services. I understand that I am financially responsible to MedCenter North, 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 MedCenter North, P.C. 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: _____

Policy Holder's DOB: _____

Policy Holder's DOB: _____

Policy Holder's SS#: _____

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Relationship: _____

Relationship: _____



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Who is your primary care physician? _____

6 MONTH UPDATE

PATIENT INFORMATION

| | | |
|---------------------------|--------------|-----------|
| Patient Name: Last: _____ | First: _____ | MI: _____ |
|---------------------------|--------------|-----------|

Address: _____

City: _____ State: _____ Zip: _____ Birthdate: _____

Home Phone Number: _____ Cell Number: _____ Sex: ____ Race: ____ Marital Status: ____

Employer: _____ Phone: _____

Social Security Number: _____ Driver's License: _____

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SIGNATURE: _____ **DATE:** _____

Witness Signature: _____ Date: _____