BIRMINGHAM PULMONARY GROUP, P.C.

DATE ________________________

Account# ______________

Driver License # ________________________

WILLIAM C. HAYS, III, M.D.
JAMES H. STRICKLAND, JR., M.D.
JAY T. HEIDECKER, M.D.

NEAL D. DANIEL, M.D.
JEFFREY J. GARNER, M.D.

ASHLEIGH REIMANN, CRNP
MICHELLE S. PRICE, CRNP
JAIME B. CANNON, CRNP

DATE OF BIRTH ________________________

FULL NAME | SOCIAL SECURITY NUMBER

ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE NUMBER | CELL PHONE NUMBER | E-MAIL ADDRESS

RACE: Circle One American Indian or Alaska Native Black or African American Caucasian/White Asian Multiracial Native Hawaiian or Other Pacific Islander Refused Declined to Specify

PREFERRED LANGUAGE: Circle One English Spanish Refused Declined to Specify

ETHINICITY: Circle One Hispanic or Latino Not Hispanic or Latino Refused Declined to Specify

EMPLOYER | WORK PHONE NUMBER (IF CALLS PERMITTED)

PRIMARY INSURANCE | POLICY OR I.D. NUMBER | GROUP# | POLICYHOLDER

SECONDARY INSURANCE | POLICY OR I.D. NUMBER | GROUP# | POLICYHOLDER

MARITAL STATUS | SPOUSE NAME | SPOUSE DATE OF BIRTH | SPOUSE EMPLOYER NAME AND TELEPHONE NUMBER

NAME AND TELEPHONE NUMBER OF PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN SPOUSE)

REFERRED BY WHOM?

PLEASE LIST OTHER PHYSICIANS INVOLVED IN YOUR CARE

PLEASE LIST ANY KNOWN ALLERGIES

I hereby assign to and authorize payment of all benefits payable under the terms of my health insurance policy (policies) to Birmingham Pulmonary Group, P.C. I request payment of authorized Medicare benefits be made on my behalf to Dr. Hays, Dr. Strickland, Dr. Heidecker, Dr. Daniel, Dr. Garner, Ashleigh Reimann, Michelle Price or Jaime Cannon for any services furnished me by that physician. I authorize the release of any medical information needed to process claims. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits.

In carrying out my treatment, it might be necessary to FAX my records to the hospital or to another doctors group. By signing below I am authorizing the release of my records in this fashion.

It is the patient's responsibility to notify this office of any insurance changes.

I understand that I am responsible for any and all charges incurred by me and that I agree to pay any collection costs incurred including a reasonable attorneys fee.

SIGNATURE | DATE