ALABAMA THORACIC SURGERY, LLC

2018 Brookwood Medical Center Dr, Ste C-214
Birmingham, AL 35209
205-453-1100 (PHONE) 205-691-9901 (FAX)

New Patient Intake Form

Today's Date: _____

Please complete the below information, to the best of your knowledge, and bring this form to your appointment.

NAME: _____ **BIRTHDATE** _____

ADDRESS: _____

PHONE: *HOME* ( ) _____ *WORK*: ( ) _____ *CELL*: ( ) _____

EMAIL ADDRESS: _____

Sex: _____ Race: _____ Ethnicity: _____ Social Security #: _____

Employer: _____ Occupation: _____

Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No Retirement Date: _____

Your Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Person To Contact In Case of Emergency: _____

Relationship To You: _____ Phone #: _____

LOCAL PHARMACY

NAME/ ADDRESS: _____

PHARMACY PHONE # ( ) _____ FAX # ( ) _____

MAIL ORDER PHARMACY

NAME/CITY/STATE: _____

PHARMACY PHONE # ( ) _____ FAX # ( ) _____

Authorization to Release Information:

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap, and/or other Insurance companies and assign my claim for medical benefits to the Practice to the extent permitted under applicable law or insurance agreements. I agree to allow the Practice to request and release my medical records from the other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow the Practice to use my medical information and photography in an anonymous manner for the purpose of teaching or publication. I release the Practice from all legal responsibility or liability that may arise from above authorizations and agreements.

Appointment Reminder Policy: I authorize this Practice and their agent to place appointment reminder phone calls and text messages to the phone I have listed on my patient form.

Consent to Treatment:

I authorize the physicians of the Practice, their associates, technical assistants, and other health care providers under their direction to provide diagnostic evaluation and treatment. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

Patient Signature: _____

Date: _____