Express Care of the Shoals

PATIENT DEMOGRAPHICS

WHEN REGISTERING, PLEASE PRESENT PROOF OF INSURANCE. ALL COPAYMENTS AND OUT OF POCKET PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

PATIENT INFORMATION

LAST NAME / FIRST NAME / MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	
	- -	/ /	M F	S M W D	
ADDRESS	**CITY**	**STATE**	**ZIP**	**HOME PHONE** ( ) -	
SPOUSE'S NAME	**PREFERRED PHARMACY**			**CELL PHONE** ( ) -	
PREFERRED METHOD OF COMMUNICATION: HOME PHONE ☐ CELL PHONE ☐				**WORK PHONE** ( ) -	
RACE: WHITE (CAUCASION) ☐ BLACK (AFRICAN AMERICAN) ☐ AMERICAN INDIAN ☐ ASIAN ☐ OTHER ☐ I DECLINE TO LIST RACE ☐					
PRIMARY LANGUAGE: ENGLISH ☐ OTHER ☐	**OCCUPATION (*PATIENT*):**				

INSURANCE #1 (PRIMARY INSURANCE - THIS WILL BE FILED FIRST)

INSURANCE COMPANY	CONTRACT NUMBER			GROUP NUMBER	
SUBSCRIBER'S LAST NAME / FIRST NAME / MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
	- -	/ /	M F	S M W D	

INSURANCE #2 (SECONDARY INSURANCE - THIS WILL BE FILED AFTER PRIMARY INSURANCE PAYS)

INSURANCE COMPANY	CONTRACT NUMBER			GROUP NUMBER	
SUBSCRIBER'S LAST NAME / FIRST NAME / MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
	- -	/ /	M F	S M W D	

EMERGENCY CONTACT INFORMATION

LAST NAME / FIRST NAME	HOME PHONE	CELL PHONE	RELATIONSHIP TO PATIENT
ADDRESS	**CITY**	**STATE**	**ZIP**

FINANCIALLY RESPONSIBLE PARTY

THIS IS THE PERSON WHO ACCEPTS RESPONSIBILITY FOR PAYMENT OF THE ACCOUNT. THIS MAY OR MAY NOT BE THE SAME PERSON THAT HOLDS THE INSURANCE CONTRACT. ALL BILLING WILL GO TO THE FINANCIALLY RESPONSIBLE PERSON, AND THIS FORM MUST BE SIGNED BY THE PERSON WHO IS FINANCIALLY RESPONSIBLE.

LAST NAME / FIRST NAME / MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
	- -	/ /	M F	S M W D	
ADDRESS	**CITY**	**STATE**	**ZIP**		
EMPLOYER / **EMPLOYER PHONE NUMBER**	**ADDRESS**				

Insurance is a contract between you and your insurance company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-insurances, non-covered charges, pre-existing conditions, coordination of benefits, secondary insurance, or "reasonable and customary" charges, however, we will assist by filing your primary insurance and secondary insurance as a courtesy.

* **I understand and realize that failure to make timely payment and maintain financial compliance is a basis for legal action and any court cost / collection fees / attorney fees will be assumed by me.**

* **I have read the financial policy and understand I am personally responsible for payment on this account in the event that my insurance deems a service to be "non-covered".**

Signature - Financially Responsible (Guarantor)

Date

network drive: FORMS/PATIENT DEMOGRAPHICS