

Patient Information

M / F

Last Name First Name M.I. Date of Birth Age Circle One

Address City State Zip

() () ()

Home Phone Cell Phone Work Phone

SS# Email Address

Employer Occupation Employer Address City State Zip

How did you hear about us? [] Yellow pages [] Seminar [] Internet [] Radio [] Newspaper [] Relative [] Other [] Physician - Please give full name, address and /or clinic detail

Family Physician Address or Clinic Name

Reason for Consultation

Spouse or Parent

Parent data needed if patient is under 18 years of age, I give my permission to have Dr. Blalock evaluate and/or treat

Parent or Guardian signature

Last Name First Name M.I. Birth Date Relationship to Patient

Mailing Address City State Zip

SS# () ()

Home Phone

Cell Phone

Employer Occupation Work Phone

Emergency Contact

In case of emergency contact: (someone not listed above)

Name: Phone #: ()

Relationship to Patient Alternative Phone # ()

Release of Medical Information and Assignment of Benefits

Cosmetic procedures are to be prepaid. We will collect co-payments at the time of services. I hereby authorize W. Stanford Blalock, M.D. to furnish my insurance company(ies) attorney, legal representatives or appropriate parties including other physicians, all information which said parties my request concerning my present illness or injury. I hereby assign to the doctor all monies to which I am entitled for medical or surgical indebtedness to said physician. It is understood that any money received from the above named parties over and above my indebtedness will be refunded when my bill is paid in full. I understand that I am financially responsible to said doctor for charges not covered by this assignment. I request that any medical records needed for my evaluation & treatment or care be released to Dr. Blalock upon his request. Patient agrees to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35% such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. You agree, in order for us to service our account, notify you of information pertaining to your account or medical condition, or for the purpose of collection, we may contact you by telephone at any number provided by you, including wireless telephone numbers. We may also contact you via e-mail or text message using any e-mail address you provide. Methods of contact may include the use of pre-recorded and artificial voice messages and/or use of an automated dialing device.

Signature of Patient (or parent if patient is under 18 years of age) Date

Name of person that completed this form

INSURANCE INFORMATION

Name and address of PRIMARY Insurance Company *(see below) Effective Date

Name of Insured Person Date of Birth Relation to Patient ID# or Social Security # Group #

NOTE: Secondary Insurances - the following information is required by Primary Insurance Carriers

Name and address of SECONDARY Carrier *(see below) Effective Date

Name of Insured Person Date of Birth Relation to Patient ID# or Social Security # Group #

*Please initial that you understand, we do / do not participate with your insurance or accept their fee schedule amount (Initials)
(circle one)

ACCIDENT INFORMATION

Date of Injury Place of Injury (at home, work, etc.) Is a lawsuit pending? Yes/No
(circle one)

If Yes, name and address of your attorney Phone#

Describe how accident happened:

WORK INJURY

(Complete this section only if you are being seen today for a work-related injury)

Did you report it to your employer? Yes/No When? _____ To Whom? _____
(Date) (Name and Title)

Name and Address of Employer at time of accident Phone #

Name and Address of Industrial Insurance Carrier (not group insurance company) Phone #

Name of Case Worker File or WCAB Case # Services authorized by (name)

EMERGENCY SERVICE

Name of Hospital Was surgery performed? Yes/No
(circle one)

Emergency Room / Outpatient / Inpatient Date Admitted _____ Date Discharged _____
(circle one)

DATE OF ADMISSION	STATUS <input type="checkbox"/> 23 hr. hold <input type="checkbox"/> Outpatient	IS YOUR CONDITION CAUSED BY AN ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE/TIME OF ACCIDENT	DO YOU HAVE AN ADVANCED DIRECTIVE? <input type="checkbox"/> Yes <input type="checkbox"/> No
FAMILY PHYSICIAN		REFERRING PHYSICIAN	SURGEON	
ALLERGIES			DIAGNOSIS	