LaToya Solomon Ph.D., BC-FNP

20 HUGHES ROAD, SUITE 101
MADISON, ALABAMA 35758
PHONE: (256) 224-4269

PATIENT INFORMATION: PLEASE PRINT

FIRST NAME: _____ MIDDLE: _____ LAST: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

PREFERRED NAME: _____ GENDER: ❑ MALE ❑ FEMALE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____) _____ CELL: (_____) _____

EMAIL ADDRESS: _____ MARITAL STATUS: _____

SPOUSE'S NAME: _____ PHONE: _____

PATIENT EMPLOYMENT STATUS: (CIRCLE) EMPLOYED / FULL TIME STUDENT / RETIRED / DISABLED

EMPLOYER: _____ WORK PHONE: _____

WORK RELATED INJURY ❑ YES ❑ NO IF YES, DATE OF INJURY: _____

RACE: _____ ETHNICITY: _____

EMERGENCY CONTACT NAME: _____

PHONE NUMBER: _____ RELATIONSHIP TO PATIENT: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

DO YOU HAVE MEDICAL INSURANCE? (CIRCLE) YES / NO

If yes, please give all insurance ID cards to the receptionist, along with your Driver's License.

PRIMARY INSURANCE NAME: _____ ID#: _____ GROUP#: _____

NAME OF INSURED ON CARD: _____ RELATIONSHIP TO PATIENT: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SSN: _____

SECONDARY INSURANCE NAME: _____ ID#: _____ GROUP#: _____

NAME OF INSURED ON CARD: _____ RELATIONSHIP TO PATIENT: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SSN: _____

TERTIARY INSURANCE NAME: _____ ID#: _____ GROUP#: _____

NAME OF INSURED ON CARD: _____ RELATIONSHIP TO PATIENT: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SSN: _____

AUTHORIZATION & ASSIGNMENT: Please read and sign the following Statement.

I directly assign all medical/surgical benefits to Your Best Health, Pediatrics and Adults and understand that I am financially responsible for all charges not covered by insurance. I hereby authorize Your Best Health, Pediatrics and Adults to release information for disability benefits if requested. I hereby authorize the Physician to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.
It is customary that payment be made when the service is rendered unless prior arrangements have been made in advance. I understand that I am responsible for any amount not covered by insurance. In the event of non-payment, either by insurance or myself, I agree to pay all cost of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract.
I hereby authorize any physician or hospital to provide copies of my medical history and treatment to Your Best Health, Pediatrics and Adults.
Photocopies of this agreement are as valid as the original.

SIGNATURE: _____ DATE: _____