250 Chateau Dr SW, Suite 115

Huntsville, AL 35803

Premier Wound Care & ID Specialist

PH: 256.533.4645

FAX: 256.808.3178

NEW PATIENT FORM

Full Legal Name:_____ Date of Birth_____/_____/_____

Preferred Name:_____Sex assigned at birth: ☐ Male ☐ Female

Patient's SSN: _____-_____-_____ Driver's License # (indicate state)_____ Age_____

Address: _____City, State, Zip:_____

Preferred Contact Phone #: _____Type (Circle One): Cell Home Work

Secondary Contact Phone #: _____ Type (Circle One): Cell Home Work

Email Address: _____Portal Access? (circle one) YES NO

Appointment Reminder Method (circle one): Phone Call (Primary #) Text (provide Cell # above) Email

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced Employment Status: ○ Employed ○ Unemployed ○ Retired

Occupation:_____Current Employer:_____Work Phone#: _____

Emergency Contact: _____Relationship_____Phone #: _____

REFERRING PHYSICIAN:_____Phone #:_____

Insurance Information

Primary Insurance Provider: _____Employer:_____

Policy/Contract ID #: _____Group #: _____Copay Amt:_____

Patient's Relationship to Insured (select one): ○ Self ○ Spouse ○ Dependent ○ Other/Worker's Compensation

Insured Date of Birth (mm/dd/yyyy)_____Insured SSN:_____ Insured Sex: ☐ Male ☐ Female

Secondary Insurance Provider: _____Employer:_____

Policy/Contract ID #: _____Group #: _____Copay Amt:_____

Patient's Relationship to Insured (select one): ○ Self ○ Spouse ○ Dependent ○ Other/Worker's Compensation

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature_____**Date**_____

I hereby authorize Scott D. Parker MD LLC and Premier Medical LLC dba Premier Wound Care and ID Specialist to file for insurance benefits on my behalf for all covered services rendered by this office. I request that payment from the insurance company be made directly to Scott D Parker MD LLC or Premier Medical LLC. I certify that the information I have reported with regard to my insurance coverage is correct, and that I will be responsible for any charges my insurance does not cover. I permit a copy of this authorization to be used in place of the original.

Signature_____**Date**_____