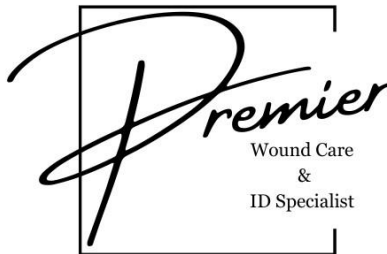


250 Chateau Dr SW, Suite 115  
Huntsville, AL 35803



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 \_\_\_\_\_