## Diabetes And Endocrine Center Of MS P O Box 2153 Dept 1975 Birmingham, AL 35201-2153

(601) 948-7313

| HOME PHONE DAY PHONE EMAIL ADDRESS PRIMARY CARE PROVIDER CITY, STATE ZIP RACE  MARITAL STATUS STUDENT STATUS SMOKER (YNI)? VETERAN (YNI)? EMERCENCY CONTACT NAME CONTACT PHONE HOME PHONE  PRIMARY EMPLOYER SECONDARY EMPLOYER (If Applicable)  ADDRESS  ADDRESS  CITY, STATE ZIP  WORK PHONE  RESPONSIBLE PARTY INFORMATION (If Different than above)  MARITAL STATUS STATE ZIP  WORK PHONE  CITY, STATE ZIP  SECONDARY BIRTHOATE LANGUAGE S  CITY, STATE ZIP  FINARY INSURANCE COMPANY  POLICY#  NAME OF INSURANCE COMPANY  COPAY AMT  S  CITY, STATE ZIP  PHONE  SSNW  BIRTHOATE  GROUP#  ADDRESS OF INSURANCE COMPANY  COPAY AMT  S  CITY, STATE ZIP  PHONE  SECONDARY INSURANCE COMPANY  COPAY AMT  S  CITY, STATE ZIP  PHONE  SECONDARY  COPAY AMT  S  COPAY AM | PATIENT INFO<br>NAME (Last, First Middle)   |  | MRN SSN#                                |                       |                  | BIRTHDATE                 | LANGUAGE                                  | SEX                 |            |  |
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| MINITAL STATUS STUDENT STATUS SMOKER (YN)? VETERAN (YN)? EMERGENCY CONTACT NAME CONTACT PHONE HOME PHONE PRAMARY EMPLOYER  SECONDARY EMPLOYER (# Applicable)  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  CITY, STATE ZIP  CITY, STATE ZIP  CITY, STATE ZIP  CITY, STATE ZIP  SECONDARY/BILLING ADDRESS (# Applicable)  SSN#  BIRTHDATE LANGUAGE IS  CITY, STATE ZIP  CITY, STATE ZIP  SECONDARY/BILLING ADDRESS (# Applicable)  ADDRESS  CITY, STATE ZIP  SECONDARY/BILLING ADDRESS (# Applicable)  ADDRESS CITY, STATE ZIP  SECONDARY/BILLING ADDRESS (# Applicable)  ADDRESS OF INSURANCE COMPANY  POLICY#  AME OF INSURANCE COMPANY  ADDRESS OF INSURANCE COMPANY  COPAY AMT  STUDENTS TATUS  SECONDARY INSURANCE (If Applicable)  ADDRESS OF INSURANCE COMPANY  COPAY AMT  SECONDARY INSURANCE COMPANY  COPAY AMT  SECONDARY INSURANCE COMPANY  ADDRESS OF INSURANCE COMPANY  COPAY AMT  SECONDARY  COPAY  | LOCAL ADDRESS CITY, STATE ZIP   |  |   | REFERRING PHYSICIAN   |                  | SECONDARY/BILLING ADDRESS |   | RESS ETHNICITY      | ETHNICITY  |  |
| PRIMARY EMPLOYER  SECONDARY EMPLOYER (If Applicable)  SECONDARY INSURANCE COMPANY  SECONDARY INSURANCE (If Applicable)  SECONDARY INSURANCE COMPANY  SE | HOME PHONE  | DAY PHONE EMAIL ADDRESS  |   | PRIMARY CARE PROVIDER |                  | CITY, STATE ZIP           |   | RACE                | RACE       |  |
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| CITY, STATE ZIP  WORK PHONE  WORK PHONE  WORK PHONE  WORK PHONE  WORK PHONE  WORK PHONE  SSNW  BIRTHDATE  LANGUAGE  SI  LANGUAGE |   |  |   | SECONDARY EMPLO       | YER (if Applicab | ole)                      |   |                     |            |  |
| WORK PHONE  RESPONSIBLE PARTY INFORMATION (if Different than above)  NAME (Last, First Middle)  SSNW  BIRTHDATE  LANGUAGE  S  LOCAL ADDRESS  CITY, STATE ZIP  SECONDARVIBILLING ADDRESS (if Applicable)  MARRITAL STATUS  STUDENT STATUS  SMOKER (VIN)? VETERAN (VIN)? PRIMARY CARE PROVIDER  HOME PHONE  HOME PHONE  RELATIONSHIP TO PATIENT  PRIMARY INSURANCE  RELATIONSHIP TO PATIENT  S  SECONDARVIBILLING ADDRESS (if Applicable)  RELATIONSHIP TO PATIENT  S  SECONDARVIBILLING ADDRESS (if Applicable)  RELATIONSHIP TO PATIENT  S  SECONDARVINSURANCE COMPANY  PHONE  PHONE  PHONE  SSNW  BIRTHDATE  S  CITY, STATE ZIP  PHONE  SECONDARY INSURANCE (If Applicable)  NAME OF INSURANCE COMPANY  NAME OF INSURANCE COMPANY  NAME OF INSURANCE COMPANY  NAME OF INSURANCE COMPANY  S  CITY, STATE ZIP  PHONE  SSNW  BIRTHDATE  SECONDARY INSURANCE COMPANY  COPAY AMT  S  CITY, STATE ZIP  PHONE  SSNW  BIRTHDATE  SECONDARY INSURANCE COMPANY  COPAY AMT  S  COPAY AMT  S  CITY, STATE ZIP  PHONE  SSNW  BIRTHDATE  SECONDARY INSURANCE COMPANY  COPAY AMT  S  CITY, STATE ZIP  PHONE  SECONDARY INSURANCE COMPANY  COPAY AMT  S  CITY, STATE ZIP  PHONE  SSNW  BIRTHDATE  SECONDARY INSURANCE COMPANY  COPAY AMT  S  CITY, STATE ZIP  PHONE  SECONDARY INSURANCE COMPANY  COPAY AMT  S  CITY, STATE ZIP  PHONE  SSNW  BIRTHDATE  SECONDARY INSURANCE COMPANY  COPAY AMT  S  COPAY AMT  S  CITY, STATE ZIP  PHONE  SSNW  BIRTHDATE  SECONDARY INSURANCE COMPANY  COPAY AMT  S  CITY, STATE ZIP  PHONE  DEDUCTIBLE  S  RELATIONSHIP TO PATIENT  S  COPAY AMT  S  CO | ADDRESS   |  | ADDRESS                                 |                       |                  |                           |   |                     |            |  |
| RESPONSIBLE PARTY INFORMATION (if Different than above)  NAME (Last First Middle)  LOCAL ADDRESS  CITY, STATE ZIP  SECONDARY/BILLING ADDRESS (if Applicable)  MARITAL STATUS  STUDENT STATUS  STUDENT STATUS  STUDENT STATUS  STUDENT STATUS  STUDENT STATUS  SMOKER (YN)?)  VETERAN (YN)?  PRIMARY CARE PROVIDER  HOME PHONE  RELATIONSHIP TO PATIENT  PROLICY#  POLICY#  POLICY#  POLICY#  POLICY#  SECONDARY INSURANCE COMPANY  SCITY, STATE ZIP  PHONE  DEDUCTIBLE  \$  RELATIONSHIP TO PATIENT  SECONDARY INSURANCE (if Applicable)  NAME OF INSURED  SSN#  BIRTHDATE  GROUP#  ADDRESS OF INSURANCE COMPANY  POLICY#  POLICY#  POLICY#  POLICY#  SECONDARY INSURANCE COMPANY  COPAY AMT  SCITY, STATE ZIP  PHONE  SECONDARY INSURANCE COMPANY  COPAY AMT  SCITY, STATE ZIP  PHONE  SECONDARY INSURANCE COMPANY  COPAY AMT  SCITY, STATE ZIP  PHONE  DEDUCTIBLE  S  RELATIONSHIP TO PATIENT  ADDRESS OF INSURANCE COMPANY  COPAY AMT  S  CITY, STATE ZIP  PHONE  DEDUCTIBLE  S  RELATIONSHIP TO PATIENT  AUTHORIZE DATE  EFFECTIVE DATE  EFFECTIVE DATE  EXPIRATION DATE  S  RELATIONSHIP TO PATIENT  AUTHORIZE DATE  AUTHORIZE DATE  REPRESSION DATE  S  RELATIONSHIP TO PATIENT  AUTHORIZE DATE  REPRESSION DATE  S  RELATIONSHIP TO PATIENT  AUTHORIZE DATE  REPRESSION DATE  S  RELATIONSHIP TO PATIENT  AUTHORIZE DATE  S  RELATIONSHIP TO PATIENT  S  RELATIONSHIP TO PATIENT  AUTHORIZE DATE  REPRESSION DATE  S  RELATIONSHIP TO PATIENT  AUTHORIZE DATE  REPRESSION DATE  S  RELATIONSHIP TO PATIENT  | CITY, STATE ZIP   |  | CITY, STATE ZIP                         |                       |                  |                           |   |                     |            |  |
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| HOME PHONE DAY PHONE EMAIL ADDRESS CITY, STATE ZIP  MARITAL STATUS STUDENT STATUS SMOKER (YM)? VETERAN (YM)? PRIMARY CARE PROVIDER HOME PHONE  RELATIONSHIP TO PATIENT  PRIMARY INSURANCE NAME OF INSURANCE COMPANY  NAME OF INSURANCE COMPANY  PHONE PHONE  RELATIONSHIP TO PATIENT  PHONE  POLICY#  SECONDARY INSURANCE (If Applicable) NAME OF INSURANCE COMPANY  NAME OF INSURANCE COMPANY  POLICY#  SECONDARY INSURANCE (If Applicable) NAME OF INSURANCE COMPANY  NAME OF INSURANCE COMPANY  NAME OF INSURANCE COMPANY  POLICY#  SECONDARY INSURANCE (If Applicable)  RELATIONSHIP TO PATIENT  SECONDARY INSURANCE COMPANY  POLICY#  SECONDARY INSURANCE (If Applicable)  RELATIONSHIP TO PATIENT  SECONDARY INSURANCE COMPANY  COPAY AMT  SCITY, STATE ZIP  PHONE  PHONE  SEFECTIVE DATE  EXPIRATION DATE  STATE ZIP  PHONE  SEFECTIVE DATE  EXPIRATION DATE  SUBJECTIVE DATE  EXPIRATION DATE  AUthorize the release of any medical information that is necessary to process a claim to my insurance company. I will give the physiciar to release my medical records to any physician that is necessary for my treatment.  I have received a copy of DECM's Privacy Policy  |   | PARTY INFOR  | RMATION (if Differe                     | ent than above        |                  |                           | BIRTHDATE                                 | LANGUAGE            | SEX        |  |
| MARITAL STATUS   STUDENT STATUS   SMOKER (Y/N)?   VETERAN (Y/N)?   PRIMARY CARE PROVIDER   HOME PHONE      Policy#   Policy#   | LOCAL ADDRESS CITY, STATE ZIP   |  |   |                       |                  |                           | SECONDARY/BILLING ADDRESS (if Applicable) |                     |            |  |
| Full-time   Part-time   Part-time   Part-time   Part-time   Part-time   PREMARY INSURANCE  | HOME PHONE  | DAY PHONE  |   |                       |                  | CITY, STATE ZIP           |   |                     |            |  |
| PRIMARY INSURANCE NAME OF INSURANCE COMPANY  POLICY#  NAME OF INSURANCE COMPANY  ADDRESS OF INSURANCE COMPANY  COPAY AMT  \$  CITY, STATE ZIP  PHONE  PHONE  EFFECTIVE DATE  EXPIRATION DATE  SECONDARY INSURANCE (If Applicable) NAME OF INSURANCE COMPANY  NAME OF INSURANCE COMPANY  NAME OF INSURANCE COMPANY  POLICY#  SECONDARY INSURANCE COMPANY  POLICY#  POLICY#  SECONDARY INSURANCE COMPANY  POLICY#  SECONDARY INSURANCE COMPANY  SECONDARY INSURANCE COMPANY |   |  | 7/N)? PRIMARY CARE PROVIDER             |                       |                  | HOME PHONE                |   |                     |            |  |
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| SECONDARY INSURANCE (If Applicable)  NAME OF INSURANCE COMPANY  SSN#  BIRTHDATE  GROUP#  COPAY AMT  \$  CITY, STATE ZIP  PHONE  DEDUCTIBLE  \$  RELATIONSHIP TO PATIENT  EFFECTIVE DATE  EXPIRATION DATE  authorize the release of any medical information that is necessary to process a claim to my insurance company. I will give the physiciar to release my medical records to any physician that is necessary for my treatment.  I have received a copy of DECM's Privacy Policy   | NAME OF INSURED   |  |   | GROUP#                |                  |                           |   |                     |            |  |
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| SECONDARY INSURANCE (If Applicable)  NAME OF INSURANCE COMPANY  ADDRESS OF INSURANCE COMPANY  SSN#  BIRTHDATE  GROUP#  COPAY AMT  \$  CITY, STATE ZIP  PHONE  DEDUCTIBLE  SEFECTIVE DATE  EXPIRATION DATE  EXPIRATION DATE  ADDRESS OF INSURANCE COMPANY  CITY, STATE ZIP  PHONE  BEFECTIVE DATE  EXPIRATION DATE  EXPIRATION DATE  Authorize the release of any medical information that is necessary to process a claim to my insurance company. I will give the physician or release my medical records to any physician that is necessary for my treatment.  I have received a copy of DECM's Privacy Policy   | CITY, STATE ZIP   |  | E                                       |                       | DEDUCTIBLE       |                           |   |                     |            |  |
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| I give my permission to release lab results or information regarding my health to:   |   |  |   | garding my health     | to:              |                           |   |                     |            |  |
|  | - Common Paris  |  |   |                       |                  |                           |   |                     |            |  |