Print Form

ASKINS & MILLER ORTHOPAEDICS, P.A.

Patient Information
(Please Print)

Today's date: _____

Patients Name_____
(LAST) (FIRST) (MIDDLE)

Local address_____City_____State_____Zip___

Billing address_____City_____State_____Zip____

Home Phone **(**___**)**_____ Cell Phone (____)_____ Local Phone (____)_____

Age_____ Date of Birth _____/____/_____ Social Security #_____
MO / DAY / YEAR

Marital Status: Single _____Married ___Divorced ___Separated ____Widowed Minor_____

If Minor, Responsible Parties: _____

Address_____Phone (___)_____

Employers Name_____

Employers Address _____City_____State_____Zip_____

Business phone (___) _____Occupation_____

Spouses Name _____Spouses Employer _____

Business Phone (__)_____Occupation_____

Person to Notify In Case of Emergency, Other Than Spouse_____PHONE (___)_____

ALL UNPAID ACCOUNT BALANCES WILL BE CONSIDERED DELINQUINT SIXTY (60) DAYS FROM THE DATE OF THE CHARGE.ANY DELINQUENT ACCOUNT REFERRED TO A COLLECTION AGENCY WILL BE RESPONSIBLE FOR THE COST OF COLLECTION INCURRED BY ASKINS & MILLER ORTHOPAEDICS, P.A., INCLUDING REASONABLE ATTORNEY'S FEES.

I HEREBY AUTHORIZE MY INSURANCE COMPANY, INCLUDING PRIVATE MEDICAL INSURANCE AND ANY OTHER HEALTH PLAN TO PAY BENEFITS TO WHICH I AM ENTITLEDFOR SURGICAL PROCEDURES TO VANCE ASKINS M.D. AND/OR DARYL MILLER M.D.

I AUTHORIZE MY PHYSICIAN TO RELEASE ANY NECESSARY INFORMATION, ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT, TO SECURE PAYMENT. I HEREBY AGREE THAT MY PHYSICIAN OR HIS DESIGNATE MAY SHARE HEALTH INFORMATION WITH OTHER PHYSICIANS WHEN SUCH SHARING IS NECESSARY FOR MY TREATMENT.

PRESCRIPTIONS RENEWAL POLICY

IT IS OUR POLICY TO RENEW PRESCRIPTIONS ONLY DURING BUSINESS HOURS. MONDAY THROUGH FRIDAY BETWEEN 8:00 AM AND 4:30 PM. PRESCRIPTIONS WILL NOT BE FILLED AFTER HOURS, AT NIGHT, WEEKENDS, OR HOLIDAYS. IF YOU CAN, ANTICIPATE WHEN YOU NEED TO REFILL YOUR PRESCRIPTION BEFORE YOUR NEXT APPOINTMENT. **PLEASE ALLOW 2-3 BUSINESSS DAYS TO RENEW YOUR PRESCRIPTIONS**.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES_____
(PATIENT OR GAURDIAN SIGNATURE)

REV 03/14/07