

SHARP & STONE OB/GYN, PC
2700 10th Avenue South, Suite 306
Birmingham, AL 35205

Charles E. Sharp, Jr., M.D.

Tim L. Stone, M.D.

Robert P. Goolsby, M.D.

PATIENT INFORMATION	
Name _____	Soc. Sec. No. _____
Preferred Name _____	Date of Birth _____ Age _____ Race _____
Email Address _____	Referred to us by _____
Street Address _____	
City, State, Zip Code _____	
Home Phone (____) _____	Cell Phone (____) _____ Work Phone (____) _____
Patient's Employer (Indicate if Student) _____	
Employer's Street Address _____	
City, State, Zip Code _____	
Spouse's or Parent's Name _____	Spouse's SSN _____
Date of Birth _____	Home Phone (____) _____ Business Phone (____) _____
Spouse's or Parent's Employer _____	
PRIMARY INSURANCE INFORMATION	
Name of Primary Insurance Company _____	Contract Number _____
Group Number _____	Effective Date _____ Expiration Date _____
Policy Holder Name (If Different Than Above) _____	
Policy Holder's Relationship to Patient _____	Sex _____ Date of Birth _____
SECONDARY INSURANCE INFORMATION	
Name of Secondary Insurance Company _____	Contract Number _____
Group Number _____	Effective Date _____ Expiration Date _____
Policy Holder Name (If Different Than Above) _____	
Policy Holder's Relationship to Patient _____	Sex _____ Date of Birth _____
IN CASE OF EMERGENCY	
Name _____	Home Phone(____) _____ Business Phone (____) _____
Relationship to Patient _____	
EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES	
<p>I hereby authorize Sharp & Stone OB/GYN, PC to release any and all information acquired in my examination, treatment and diagnosis to my insurance carriers and other treatment physicians. If I am covered by insurance, I will furnish my insurance card and signature.</p> <p>I hereby assign and authorize payment directly to Sharp & Stone OB/GYN, PC any medical and surgical benefits otherwise payable to me. Should an insurance payment be received that is less than the physician's usual charge for the services provided, I will be responsible for the difference. I understand if my insurance provider denies payment for any service for any reason I will be responsible for those charges.</p> <p>I also agree to pay all cost of collection including, but not limited to reasonable attorney's fee, and waiver all claims of exemption under the law of the state of Alabama. Form must be signed and dated by patient or responsible party.</p>	
Date _____	X _____ Patient and/or Responsible Party