SAWYER SURGERY CLINIC, LLC
101 E. BRUNSON ST, STE 300
ENTERPRISE, AL 36330

Welcome to our office. In order to care for you, we need the following information.
All information is strictly confidential.

Patient's Name:______________________________ DOB: ___________________
Address: ___________________________________ AGE:____________________
City, State:____ Zip Code:________________
Phone Numbers:
Home:___________________ Work:__________________ Cell:____________________
Employer:
_____________________________________ Marital Status:
Address: Married/ Single/ Widowed/ Divorced
_____________________________________ Sex: _____Male ____Female
____
SSN:_________________________________ Race:__________________________
Email: (optional)____
Preferred Pharmacy:____

If Patient is 18 years old or younger:

Father:_________________________ Mother:________________________________
Address:_______________________ Address:_______________________________
_______________________________ _______________________________________
Employer:______________________ Employer:______________________________
Work Phone:____________________ Work Phone:____________________________
SSN:___________________________ SSN: _________________________________

Release of Information

I hereby authorize Sawyer Surgery Clinic, LLC to release any and all of my medical information including the diagnosis, progress notes, x-ray reports, scheduled appointments and any additional information related to my care with the following individuals:

___________________________(Spouse, parent, other) DOB ________________Phone:_________________

___________________________(Spouse, parent, other) DOB ________________Phone:_________________

TREATMENT/INSURANCE/ASSIGNMENT/FINANCIAL AUTHORIZATION:

I hereby authorize Sawyer Surgery Clinic, LLC to render treatment and to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the physician(s) all payments for medical services rendered on behalf of me or my dependents. I understand that I am financially responsible for any amount not covered by insurance(s). I further agree that, in the even of non-payment by the insurance carriers, I will bear the cost of collection, including a 33 1/3% collection fee, Attorney fees, and/or Court Costs, should this be required.

SIGNED:___________________________________ DATE:______________