



AVALON
— MEDICAL GROUP —

2400 E. Avalon Avenue, Muscle Shoals, AL 35661
256-386-0808

Patient Information

SSN: # _____ - _____ - _____

SEX: M ___ F ___

Last Name: _____ Suffix: _____

First Name: _____ MI: _____

Address: _____

Date of Birth: ___ / ___ / _____

Marital Status: S M D W

Spouse Name: _____

Spouse Date of Birth: ___ / ___ / _____

Race: _____

Primary Language: _____

Ethnicity: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Employer: _____

Occupation: _____

_____	_____	_____
Person to Notify In Case of Emergency	Relationship	Phone Number

Authorization to Release Medication Information: _____

Authorization of Assignment of Benefits: _____

Our professional services are rendered to you, not the insurance company. We will make every attempt we can file your insurance, ultimately if they do not pay you are responsible for any balance due.

I further agree, that if I fail to make timely payments on my account, I will be responsible for any and all costs associated with collections.

Signature: _____ Date: _____