Stewart Hill Tankersley, M.D.
4154 Carmichael Caourt • Montgomery, AL 36106 • P: (334) 593-0193 • F: (334) 593-1693

PATIENT INFORMATION

Date _____/_____/_____ **Date of Birth** _____/_____/_____

Last Name ______________________ **First Name** ______________________ **Middle Initial** ____ **Nickname** ______________

SSN (last 4 digits) ____________ **Gender** ☐ Male ☐ Female **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address______________________ **City**______________ **State**_____ **Zip Code**__________

Home Phone (________) ______________ **Cell Phone** (________) ______________ **Work Phone** (________) ______________

Employer ______________________ **Phone** (________) ______________

Email Address ______________________ **May we email or send you texts to confirm appointments?** ☐ Yes ☐ No

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self *(skip to next section)* ☐ Spouse ☐ Parent ☐ Other ______________ **Date of Birth** _____/_____/_____ **SSN (last 4 digits)**__________

Last Name ______________________ **First Name** ______________________ **Middle Initial** ____ **Nickname** ______________

Home Address______________________ **City**______________ **State**_____ **Zip Code**__________

Home Phone (________) ______________ **Cell Phone** (________) ______________ **Work Phone** (________) ______________

Employer ______________________ **Phone** (________) ______________

EMERGENCY CONTACT INFORMATION

1. Name ______________________ **Relationship to Patient** ______________ **Phone** (________) ______________

2. Name ______________________ **Relationship to Patient** ______________ **Phone** (________) ______________

RELEASE OF MEDICAL INFORMATION

Relationship to Patient ☐ Spouse ☐ Parent ☐ Other ______________________

Last Name ______________________ **First Name** ______________________ **Middle Initial** ____ **Nickname** ______________

Home Address______________________ **City**______________ **State**_____ **Zip Code**__________

Home Phone (________) ______________ **Cell Phone** (________) ______________ **Work Phone** (________) ______________

PLEASE PRESENT YOUR DRIVERS LICENSE AND INSURANCE CARD(S) TO THE RECEPTIONIST

I hereby authorize Stewart Hill Tankersley, M.D. to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Stewart Hill Tankersley, M.D. for any insurance benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier, regardless of insurance benefits, if any. I understand that I am fully responsible for any and all fees incurred and I agree the above is legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees and/or court costs. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I realize that extraordinary circumstances, some insurances companies will not pay for certain procedures (i.e. MRI's or Ultrasounds.) I understand that my insurance is filed as a courtesy and I am responsible for the bill.

______________________________ ______________

Patient/Responsible Party Signature **Date**

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.
I have also seen the HIPPA information (provided in the lobby) for Stewart Hill Tankersley, M.D.

______________________________ ______________

Patient/Responsible Party Signature **Date**