

**St. Vincent’s at Samford University Health Services**

**PATIENT INFORMATION**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Samford ID:\_900\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ Male Female**

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**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: ( ) - Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@samford.edu**

**INSURANCE INFORMATION**

**Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy/Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization to pay benefits to physician / office: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to the provider when he/she accepts assignment.**

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**Signature of Patient (or authorized representative)**  **Date**