

SOUTHEASTERN SURGICAL SPECIALISTS, P.C.  
GENERAL & LAPAROSCOPIC SURGERY

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PATIENT INFORMATION

Name: \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Spouse: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_

Father (If minor): \_\_\_\_\_ Mother (If minor): \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Mail Bill to: \_\_\_\_\_

EMERGENCY NUMBER: (OTHER THAN YOUR HOUSEHOLD)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Subscriber: \_\_\_\_\_

I hereby authorize any insurance company to pay the proceeds of my benefits directly to **Southeastern Surgical Specialists, P.C.**

A copy of this can be considered as an original for insurance purposes. With this copy, I authorize any information including the diagnosis and records of any treatment of examination rendered to me to be released to said insurance company.

I understand that I am responsible for all charges for all services rendered to me or any member of my family. In the event of non-payment of my account, I agree to pay a reasonable attorney's fee and costs associated with collection including, but not limited to, publication, process server and fees and court costs.

By signature below, I certify that I have read and understand the above statements, and hereby voluntarily consent to medical care and treatment by the staff of **Southeastern Surgical Specialists P.C.**

Signature \_\_\_\_\_

Date \_\_\_\_\_