# Patient Information Sheet

## PLEASE PRINT

**Your Name**: _____ **Doctor of Record:** _____

**Social Security Number**: _____ **Date of Birth**: _____

Home Address: _____City: _____State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Gender ___Male ___Female

Email Address: _____(required for secure messaging/patient portal)

Text/Carrier: _____

Guarantor Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip:_____

Primary Insurance Company: _____

Contract Number: _____ Group Number: _____ Co-Pay $ _____

Insurance Address: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

How are you related to the policy holder: Self Spouse Child Other: _____

Secondary Insurance Company: _____

Contract Number: _____ Group Number: _____ Co-Pay $ _____

Insurance Address: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

How are you related to the policy holder: Self Spouse Child Other: _____

Marital Status: ___Single ___Married ___Divorced ___Widowed Language: _____

Employment Status: ___Student __Employed Full-Time __Employed Part-time __ Retired __Unemployed __Disabled

Race:_____ Ethnicity _____

**Pharmacy Name**: _____ Location:_____ Telephone:_____

In case of an emergency, who should we contact:

Name: _____ Relationship: _____

Primary Telephone: _____ Secondary Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

I, the undersigned, authorize payment of medical benefits for any services furnished to me by the practitioner. I understand that I am financially responsible for any amount not covered by my insurance. I understand that I am required to pay all co-pays, deductibles or non-covered services at the time of service.

Date: _____/_____/____ Signed _____

_____ _____

Print Name of Parent or Guardian Signature of Parent or Guardian

Pell City Internal and Family Medicine

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