Primary Care Pediatrics
and Family Medicine

29869 Capshaw Road, Harvest, AL 35749
Phone:256-262-1040

FAMILY MEDICINE PATIENT DEMOGRAPHICS:

Last Name: ___________________First Name __________________Middle Name: ________________
SS #_________________ Sex: Male/ Female Marital Status: _______Date of Birth___/____/___
Race: _______________Ethnic Group ______________Primary Language Spoken: ________________
Home Address: _________________________________City ________________State ____ Zip_______
Phone: Home (___) _________________ Cell (___) ________________ Work (___) ________________
Email: ____________________________________
Employed? Yes/No Employer: ___________________________ Occupation: _________________
Retired: Yes/No

RESPONSIBLE PARTY INFORMATION (if not self)

Full Name: ____
Relationship with patient: ____________
SS #_______________ Marital Status: _______Date of Birth___/____/___
Home Address: _________________________________City ________________State ____ Zip_______
Phone: Home (___) ______ Cell (___) ________Work (___) _______ Email: _____________________
Employer: ________________________________ Occupation: __________________ Retired: Yes/No

EMERGENCY CONTACT:

Name	Relationship	Address	Phone

PREFERRED PHARMACY (name, location, phone number)

____

Primary Care Pediatrics and Family Medicine P.C. may contact me via: ___Phone ___Portal
Primary Care Pediatrics and Family Medicine, P.C may leave messages or lab results via
___Phone: ____Home ____Cell ___Portal

___Primary Care Pediatrics and Family Medicine, P.C., may not leave message or lab result.

Primary Care Pediatrics and Family Medicine may send me appointment reminder via
__ Email ___ Text

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Please list the names and telephone numbers of the family members involved in your care, to whom we can talk about your health information:

Name	Phone Number	Relationship	Permission (Y/N)

Previous Family Physician: ____________________________ Tel: (___) _____________
Reason for leaving____
How did you hear about us? __Website __Google search__ Medical Insurance __Facebook
___Outdoor signs __Friends/ Family __Others

INSURANCE INFORMATION:
Primary Insurance _________________ Insured's Name _____________________DOB__________
Group No.___________________________ Contract No.__________________
Secondary Insurance ________________Insured's Name_________________ DOB____________
Group No.___________________________ Contract No.__________________

I hereby attest that I am eligible member of above mentioned health plan. I hereby authorize and direct payment to Primary Care Pediatrics and Family Medicine P.C, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I hereby authorize Primary Care Pediatrics and Family Medicine, P.C. to release any information acquired in the course of my treatment necessary to my insurance company for the purpose of processing insurance claims. I understand that regardless of my insurance status, I am solely responsible for payment of any services rendered to me, or on my behalf, whether or not paid by my insurance.

Patient / responsible party's signature Date

_____________________________________ ____________

Name:

____