Primary Care Pediatrics
and Family Medicine
29869 Capshaw Road, Harvest, AL 35749
Phone:256-262-1040

PATIENT DEMOGRAPHIC:

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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PATIENT DEMOGRAPHIC:

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.

In the event of non-payment or default, I am responsible for all costs of collections, including, but not limited to, collection agency fees, court costs, and reasonable attorney fees.

_____ _____ _____
Signature of Patient/Responsible Party Name of Responsible Party Date