FAMILY CARE

ASSOCIATES, PC

1855 Halcyon Blvd.
Montgomery, AL 36117
334-530-6387

Would you like to sign up for Patient Portal? Yes__ No __

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

Patient Name: _____ Sex: ☐M ☐F Social Security #: _____/_____/_____

Marital Status: ☐Single ☐Married ☐Widow/er ☐Divorced ☐Partner Date of Birth: _____/_____/_____ Age: _____

Race: _____ Ethnic Group: ☐African American ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other: _____

Language if not English: _____ Other Communication issues: ☐Yes ☐No Detail: _____

Mailing Address: _____
Street Apt No. City State Zip

Physical Address (if not the same as mailing): _____
Street Apt No. City State ZIP

Home Phone: (_____) _____-_____ Cell/pager: (_____) _____- _____ Work phone: (_____) _____-_____

Email Address: _____ Preferred Contact Method: ☐Text ☐Mail ☐E-Mail ☐Phone

Reminder method: ☐Work Phone ☐Home Phone ☐Cell Phone ☐E-Mail Driver License No: _____ _____ Expires: _____
Number State

Spouse/Partner Name: _____ Date of Birth: ___/___/___ Social Security No: ___/___/_____

Address: _____ Work Phone: (____) _____ - _____
Street Apt No City State Zip

Emergency Contact Name: _____ Emergency Contact No: (_____) _____ - _____

Address: _____ Relationship: _____
Street Apt No City State Zip

GUARANTOR/PARENT INFORMATION

Responsible Party: _____ Date of Birth: ___/___/___ Sex: ☐M ☐F Security No: _____/_____/_____

Marital Status: ☐Single ☐Married ☐Widow/er ☐Divorced ☐Partner Drivers License No: _____ _____ Expiration Date: _____
Number State

Home Phone: (_____) _____-_____ Cell/pager: (_____) _____- _____ Work phone: (_____) _____-_____

Employer: _____ Occupation: _____

Address: _____ Relationship to Patient: _____

PATIENT'S INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance Company's Name: _____

General Phone: (_____)_____-_____ Claims Phone: (_____)_____-_____ Office fax: (_____)_____-_____

Insurance Address: _____
Street Apt No City State Zip

Policy Holder: _____ Date of Birth: _____/_____/_____ Social Security No: _____/_____/_____

Insurance ID No: _____ Insurance Group No: _____

Secondary Insurance Company's Name: _____

General Phone: (_____)_____-_____ Claims Phone: (_____)_____-_____ Office fax: (_____)_____-_____

Insurance Address: _____
Street Apt No City State Zip

Policy Holder: _____ Date of Birth: _____/_____/_____ Social Security No: _____/_____/_____

Insurance ID No: _____ Insurance Group No: _____

(Please Read And Sign)

I herby authorize my insurance benefits to be paid directly to Family Care Associates, PC and I realize I am responsible for paying for non-covered services. I understand that I am responsible for all charges incurred on my behalf, including any added costs incurred due to any effort to collect for services rendered. I hereby authorize the release of pertinent medical information to insurance carriers.

Patient/Guardian Signature: _____ **Date:** _____