Hartselle Family Practice

Phone: (256) 773-6017 Fax: (256) 773-7834

PATIENT INFORMATION

PLEASE PRINT DATE_____

Patient's Name_____ **Date of Birth** _____
LAST FIRST MI

Address_____City_____State_____Zip _____

SS# _____ **Sex:** Male Female **Marital Status:** Single/Mar/Div/Sep/Widow

Ethnicity (circle one): Caucasian; Black/African American; Hispanic; Asian; Native American; More Than One Race; Other _____

Home Phone_____**Work Phone**_____**Mobile Phone**_____

Preferred Contact Phone (circle one): Home – Work - Mobile May we leave a message for you on this phone? Yes No

Email Address _____

Patient's Occupation_____**Employer:**_____

Employer's Address_____**Employer's Phone** ( )_____

Spouse's Name_____**Spouse's D.O.B.**_____/_____/_____**Spouse's SS #**_____-_____-_____

Spouse's Occupation_____**Spouse's Employer**_____

Employer's Address_____**Employer's Phone** ( ) _____

Notify in case of emergency_____ **Relationship** _____

City_____**State**_____Phone ( ) _____

PRIMARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

SECONDARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

PERSON RESPONSIBLE FOR THIS ACCOUNT_____PHONE ( )_____

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles, and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs, and attorney's fees. I authorize Hartselle Family Practice to release information to insurance carriers and for insurance carriers to release information to Hartselle Family Practice concerning my illness, treatment, and payments (including workmen's compensation). I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature_____Date_____Time_____