ALPHA FAMILY MEDICINE

480 North Main Street, Suite 202, Alpharetta GA 30009
Phone: 678-619-1974 www.alphafammed.com

PATIENT INFORMATION FORM

ALL PATIENTS OR RESPONSIBLE PARTIES MUST COMPLETE THIS FORM AND PROVIDE A PICTURE ID AND INSURANCE CARD BEFORE SEEING A MEDICAL PROVIDER.

LAST NAME_____ FIRST NAME_____ M.I._____

ADDRESS_____ CITY_____

STATE_____ ZIP_____ (HOME) PHONE_____ (WORK)_____

E-Mail Address_____ (CELL) PHONE_____

SSN_____ BIRTHDATE_____ SEX (M)_____ (F)_____

RACE (Please circle): Asian African Am. Hispanic White Refuse Other_____ MARITAL STATUS: S M W D

PREFERRED LANGUAGE_____ ETHNICITY (Please Circle): Hispanic Not Hispanic Refuse

EMERGENCY CONTACT NAME_____ **PHONE**_____

INSURANCE CARRIER_____ INSURANCE #_____

INSURED'S NAME_____ INSURED'S BIRTHDATE_____

RELATIONSHIP TO PATIENT_____

INSURED'S EMPLOYER_____

EMPLOYER'S ADDRESS_____

SECONDARY INSURANCE CARRIER_____ INSURANCE #_____

INSURED'S NAME_____ _____ INSURED'S BIRTH DATE_____

IF PATIENT IS A MINOR, COMPLETE NEXT TWO LINES

FATHER'S NAME_____ PHONE_____
MOTHER'S NAME_____ PHONE_____

Pharmacy phone # and address _____

IN ORDER TO MAINTAIN CONTINUITY OF CARE, I GIVE PERMISSION TO ALPHA FAMILY MEDICINE TO RELEASE MY MEDICAL RECORDS TO ANY SPECIALISTS, HOSPITALS OR MEDICAL FACILITIES ASSOCIATED WITH MY CARE PLAN. I UNDERSTANDTHAT ALPHA FAMILY MEDICINE ABIDES BY HIPAA REGULATIONS AND THAT ONLY THE RECORDS PERTINENTTO THE VISIT WILL BE RELEASED.

SIGNED_____Date_____