



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 DOCTOR

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 _____ INSURED'S SSN _____

INSURED'S NAME _____ INSURED'S BIRTHDATE _____

RELATIONSHIP TO PATIENT _____

INSURED'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

SECONDARY INSURANCE CARRIER _____ INSURED'S SSN _____

INSURED'S NAME _____ INSURED'S BIRTH DATE _____

IF PATIENT IS A MINOR, COMPLETE NEXT TWO LINES

FATHER'S NAME _____ PHONE _____

MOTHER'S NAME _____ PHONE _____

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 UNDERSTAND THAT ALPHA FAMILY MEDICINE ABIDES BY HIPAA REGULATIONS AND THAT ONLY THE RECORDS PERTINENT TO THE VISIT WILL BE RELEASED.

SIGNED _____