# *Alabama Family Practice, P.C.*

*370 St. Lukes Drive*
*Montgomery, AL 36117*
*Phone: (334) 213-3606* *Fax: (334) 213-3608*

## PATIENT INFORMATION

PATIENT'S NAME: _____ _____ ____ ____
Last First Middle Date of Birth Age Sex

ADDRESS_____
Street Address City State Zip

_____ _____ _____
Social Security Number Driver's License Number Marital Status

_____ _____
Occupation Employer's Name and Address

_____ _____
Home Phone Business Phone

SPOUSE'S NAME: _____ _____
Last First Middle Occupation

_____ _____
Employer's Name and Address Business Phone

NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU: _____

_____ _____
Relationship Phone Number

REFERRED BY: _____

### MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY: _____ SUBSCRIBER NAME: _____

CONTRACT/ POLICY # _____ GROUP # _____

OTHER INSURANCE COMPANY: _____ SUBSCRIBER NAME: _____

CONTRACT/ POLICY # _____ GROUP # _____

**PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL**

PATIENT'S NAME: _____ _____ ____ ____
Last First Middle Date of Birth Age Sex

ADDRESS_____
Street Address City State Zip

_____ _____ _____
Home Phone Relationship to Patient Occupation

_____ _____
Employer's Name and Address Business Phone

METHOD OF PAYMENT (Please ✓ one) ☐ Cash ☐ Check ☐ MC/VISA/Discover ☐ Other

**PLEASE READ BEFORE SIGNING,** Authorization is hereby given to release such information as may be necessary for the completion of my hospital/medical claims. I further agree to pay all medical expenses incurred resulting from this treatment and authorization, and I assign any insurance benefits applicable. I waive any right which I may have according to the Constitution and laws of Alabama, or any other state, to claim exemption as to personal property as to this obligation, and if this obligation is not paid in full when due, I agree to pay all cost of collecting it, including reasonable attorney's fee.

I understand I am financially responsible to the physician for routine charges and charges not covered by my assigned insurance contract. All charges are doe at time of service. I further understand that the office accepts no liability for failure to meet any pre/post admission certification procedures which may be required of me by my coverage carrier and I agree that any such procedure have or will be executed by me.

_____ _____
Signature of Patient or Legal Guardian Date

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NAME: _____ TODAY'S DATE: _____ AGE: _____

BIRTH DATE: _____ BIRTH PLACE: _____

OCCUPATION: _____ STATES YOU HAVE LIVED: _____

ALLERGIES: _____

**PAST MEDICAL HISTORY** (Check ALL that apply):

Childhood illness:_____ Anemia: _____

Eye, Ear, Nose, or Throat Issues: _____ Hypertension: _____

Hypercholesterolemia: _____ Heart Disease/ Failure: _____

Lung Disease: _____ Kidney Disease: _____

Stomach or Colon Disease: _____ Arthritis: _____

Other Disease or Disorder NOT listed above: _____

**FAMILY MEDICAL HISTORY** (Check ALL that apply and relation):

| | | | |
|---|---|---|---|
| _____ Autoimmune Disease | _____ Heart Disease | _____ Seizures | _____ Cancer |
| _____ Bleeding Disorder | _____ Hypercholesterolemia | _____ Stroke | ___ Breast |
| _____ Colon Polyps | _____ Hypertension | _____ Thyroid Disease | ___ Colon |
| _____ Diabetes | _____ Mental Disorder | _____ Other | ___ Prostate |

**PAST SURGICAL HISTORY:**

_____

_____

_____

**PAST HOSPITALIZATIONS:**

_____

_____

_____

**REVIEW OF SYSTEMS** (Check ALL that apply):

| | | | |
|---|---|---|---|
| ___ Rashes | ___ Nausea, Vomiting | ___ Chest Pain | ___ Vomiting Blood |
| ___ Headaches | ___ Diarrhea | ___ Hypertension | ___ Urinary Frequency |
| ___ Hearing Loss | ___ Breast Pain or Discharge | ___ Exertional Shortness of Breath | ___ Blood in Urine |
| ___ Visual Loss or Disturbance | ___ Breast Mass | ___ Swelling | ___ Increased Thirst |
| ___ Ringing in the Ears | ___ Shortness of Breath | ___ Fainting | ___ Impotence |
| ___ Difficulty Swallowing | ___ Cough | ___ Hiatal Hernia | ___ Seizures |
| ___ Hoarseness: Chronic | ___ Asthma | ___ Abdominal Pain | ___ Tremors |
| ___ Bleeding Gums | ___ Coughing Blood | ___ Hepatitis | ___ Muscle Aches |
| ___ Weight Loss | ___ Night Sweats | ___ Blood in Stool | ___ Paralysis |
| ___ Weight Gain | ___ Heart Palpitations | ___ Ulcers | ___ Numbness |
| **Menses history:** | ___ Age at Onset of Menses | ___ First Day of Last Menses | ___ Painful Menses |
| ___ Heavy Menses | ___ Number of Pregnancies | ___ Number of Children | ___ Number of Miscarriages |

**SOCIAL:**

**Do you drink alcohol? _____ How Long? _____**

**Do you Smoke? _____How Long? _____ How Many Packs Per Day? _____**

**Provider's Signature: _____ Date: _____**