Medical Record # **Date**

PATIENT DATA

FULL NAME: ____
Last First Middle

ADDRESS: ____

____ Email: ____________________
City State Zip Code

TELEPHONE#: ____________________(Home) TELEPHONE#: ____________________(Work)

SOCIAL SECURITY# : ____________________ AGE ______ DATE OF BIRTH __________ SEX _______

MARITAL STATUS: MARRIED ( ) DIVORCED ( ) WIDOWED ( ) SINGLE ( )

RACE: WHITE ( ) BLACK ( ) ASIAN ( ) AMERICAN INDIAN/ALASKIAN ( ) PACIFIC ISLANDER ( )

ETHNICITY: NON-HISPANIC/LATINO ( ) HISPANIC/LATINO ( )

LANGUAGE: ENGLISH ( ) SPANISH ( ) OTHER:____________________

EMERGENCY CONTACT DATA

NAME: ______________________________________ RELATIONSHIP: ____________________

ADDRESS: ____

____
City State Zip Code Phone#

PATIENT'S EMPLOYMENT DATA

COMPANY NAME: ____

ADDRESS: ____

____
City State Zip Code Phone#

OCCUPATION:

RESPONSIBLE PARTY *(If other than the patient - Patient is responsible unless a minor)*

NAME: ____

STREET: ____
City State Zip Code

PHONE#: ____________________ DATE OF BIRTH: ______________ SSN: ____________________

EMPLOYER NAME: ____

____
Address City State Phone#

ARE SERVICES COVERED BY INSURANCE? ( ) YES ( ) NO WHAT IS YOUR CO-PAYMENT? __________

CONSENT FOR TREATMENT:

I consent for treatment as necessary or desirable to the care of the patient first named above, including but not restricted to, whatever drugs, medicine, and conduct of laboratory x-ray or other studies that may be used by the attending doctor, nurse or qualified designate. I the undersigned accept the fee charged as a lawful debt and promise to pay said fee, including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

Date: ______________________ **Signed:** ______________________________
Patient/Parent or Guardian