

ADULT



Patient's Name _____

First

Middle Initial

Last

Date of Birth: _____ Social Security #: _____

Marital Status: S M W D

Gender: Male or Female

Race: _____

Ethnicity: Hispanic Non-Hispanic Other

Primary Phone #: _____ Secondary Phone #: _____

Preferred Method of Contact: _____ Ok to leave Voice Message: Yes No

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip Code: _____

Employer Name: _____

Work Phone #: _____ Position: _____

Emergency Contact Name: _____ Relation: _____

Date of Birth: _____ Previously seen at this clinic: Yes No

Primary Phone #: _____ Secondary Phone #: _____

Preferred Method of Contact: _____ Ok to leave Voice Message: Yes No

Preferred Pharmacy Information

Name: _____ Phone #: _____

Street/ City/ State: _____

Reason For Today's Visit/ Symptoms: _____

Primary Care Physician: _____

Name of Primary Office: _____

ADULT

Primary Insurance: _____

Policy/ Contract/ ID #: _____ Group #: _____

Name of Primary Insured: _____ Relation to patient: _____

Primary Insured Date of Birth: _____ Social Security #: _____

Secondary Insurance (If Any): _____

Policy/ Contract/ ID #: _____ Group #: _____

Name of Primary Insured: _____ Relation to patient: _____

Primary Insured Date of Birth: _____ Social Security #: _____

I authorize the following individuals listed below to be given information concerning my health and wellbeing. Information may include appointments, test results, and medications. **(Must also include your Emergency Contact/ Spouse)**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other medical conditions (please list):

ADULT

Consent to Treat

I hereby give authorization to all the physicians and staff at South Alabama Family Care to treat myself. I understand that there are no guarantees regarding the result of treatment and/or examinations.

Initial: _____

Electronic Communications

SAFC, and/or our agents may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using the email address you provide to use.

Initial: _____

Financial Responsibility

Payment is due at the time of service. I understand I will be expected to pay any deductibles, co-payments, and fees at the time of any office related service. I will be responsible for any patient balances after insurance has been filed. I understand that South Alabama Family Care has the right to refer my account to an outside collection's agency after a period of 90 days. I hereby give authorization for payment of insurance benefits to be made to South Alabama Family Care for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In case of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare facility to release all information necessary to secure payment of benefits and that a photocopy of this agreement shall be as valid as the original

Initial: _____

Notice of Rights, Responsibilities, and Privacy- Summary

- SAFC can/will use my health information for the purpose of medical treatment, to obtain payment for treatment, and SAFC's health care operations.
- SAFC can/will also use and share my health information as required/permitted by law.
- I am responsible for following instructions about care and treatment and understanding the consequences if I do not follow them as directed by the clinical staff.
- I am responsible for giving complete and accurate information about my health and my medical history, as it is vital to my medical treatment.

Acknowledgement of Receipt for the Privacy Practices/ Patient Rights

I acknowledge that the South Alabama Family Care's Notice of Privacy Practices and the Patient Rights are posted for view in the lobby and listed above, and printed copy is available upon request from the front desk staff. The notice explains in detail my individual rights and how I may exercise these rights

Patient's Complete Legal Name: _____

(Please Print)

Patient's DOB: _____ Date: _____

Signature: _____ Witness: _____
Patient or Legal Representative Staff

May be requested to show proof of representative status