Fairhope Family Medicine, LLC
21875 Hwy 181
Fairhope, AL 36532
251-928-1442
251-210-0969 fax

Patient Information Sheet

Please print clearly. Complete all information to allow quick and efficient processing of your claim.

PATIENT INFORMATION

Name (First)_____ (MI)_____ (Last)_____ Age _____
Date of Birth _____ Gender _____ Social Security # _____
Preferred Name _____ Language _____
Race _____ Ethnicity (please circle one) Hispanic or non-Hispanic
Address (Street) _____ (PO Box) _____
(City, State, Zip)_____
Home Phone # _____ Work Phone _____
Cell Phone # _____ Driver's License # _____
Employer _____Employer Phone #_____
E-mail address _____

Living Will/Healthcare POA yes no, if yes please provide a copy

Patient's Marital Status _____ if married, please provide the following information about your spouse:

Name (First)_____ (MI)_____ (Last)_____ Age _____
Date of Birth _____ Gender _____ Social Security # _____
Address (Street)_____ (PO Box) _____
(City, State, Zip)_____
Home Phone # _____ Work Phone _____
Cell Phone # _____ Driver's License # _____
If Student, School _____ Employer Phone # _____
Employer_____
Employer's Address_____

RESPONSIBLE PARTY INFORMATION (if different than patient)

Name (First)_____ (MI)___ (Last)_____ Relationship _____
Date of Birth _____ Gender _____ Social Security # _____
Address (Street)_____ (PO Box) _____
(City, State, Zip)_____
Home Phone # _____ Work Phone_____
Cell Phone # _____ Driver's License # _____
If Student, School _____ Employer Phone # _____
Employer_____
Employer's Address_____

**Please provide information for any Additional Responsible Parties or Parents on reverse.

Please provide contact information for a friend or relative not living with you:
Name _____ Relationship_____
Phone # _____

Please turn over ↘

PRIMARY INSURANCE INFORMATION

Medicare # _____ (number only, no address needed)

Insurance Company _____ Phone #_____
Insurance Address _____
Group # _____ Contract or ID # _____
Insured's Name _____ Relationship to patient _____
Insured's Address_____
Insured's Social Security # _____ Insured's Date of Birth _____
Insured's Phone # _____
Insured's Employer _____ Employer Phone # _____
Insured's Employer's Address_____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Phone # _____
Insurance Address _____
Group # _____ Contract or ID # _____
Insured's Name _____ Relationship to patient _____
Insured's Address_____
Insured's Social Security # _____ Insured's Date of Birth _____
Insured's Phone # _____
Insured's Employer _____ Employer Phone # _____
Insured's Employer's Address _____

Please provide additional Parent or Responsible Party information below, if applicable:

Name (First)_____ (MI)___ (Last)_____ Relationship _____
Date of Birth _____ Gender _____ Social Security # _____
Address (Street)_____ (PO Box) _____
(City, State, Zip)_____
Home Phone # _____ Work Phone #_____
Cell Phone # _____ Driver's License #_____
If Student, School _____ Employer Phone #_____
Employer/Address _____

I hereby assign, transfer, and set over to Fairhope Family Medicine, LLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____
Signature of Patient/Legal Guardian Date