SHOALS HEALTH GROUP
PATIENT INFORMATION

Last name _____ First Name _____ Middle Name _____

Address _____ City _____ State _____ Zip code _____

Home phone _____ Work Phone _____ Cell phone _____

Ok to leave messages regarding medical condition such as, lab reports, test results, medications, and appointments: YES NO

Which phone number is the primary number to be called: HOME PHONE CELL PHONE WORK PHONE (Circle one)

Social Security # _____ Birthdate: _____ Age: _____

E-Mail address: _____

☐ FEMALE ☐ MALE ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

Employer _____ Employer phone _____

Employer address _____

If not employed, are you disabled? YES NO Do you require a wheelchair van or ambulance for transport? YES NO

Referring physician: _____ Family Physician: _____

Pharmacy Name _____ Town _____ Phone: _____

Do you wish for your information from this practice to be mailed to an alternate address? YES NO
If yes:
Address:_____ City:_____State:_____Zip:_____

EMERGENCY CONTACT INFORMATION

Last name _____ First Name _____ Middle Name _____

Address _____ City _____ State _____ Zip code _____

Home phone _____ Work Phone _____ Cell phone _____

Relationship to patient _____

INSURANCE INFORMATION

Primary insurance _____

Secondary insurance _____

Other insurance _____ _____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments; however, the patient is responsible for ALL fees, regardless of insurance coverage. Payment is due when services are rendered, unless other arrangements have been made in advance with the office manager. Co-pays are due at the time of service.
I authorize payment of medical benefits to Shoals Health Group. I also authorize the release of any medical or financial information necessary to obtain payment on my behalf.

Signature _____ **Date** _____