South Alabama
MEDICAL CLINIC

**Patient Demographic Information**

Patient's Name _____

First Middle Initial Last

Date of Birth: _____ Social Security #: _____

Marital Status: S M W D Gender: Male or Female Race: _____ Ethnicity: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different):_____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Employer Name: _____

Work Phone #: _____ Position: _____

**Spouse's Name** _____

Date of Birth: _____Social Security #: _____

Home Phone #: _____ Cell Phone #: _____

Employer Name: _____ Work Phone #: _____

**Emergency Contact Name:** _____

Phone #: _____Relation:_____

**Primary Insurance:** _____

Policy #: _____ Group #: _____

Name of Primary Insured: _____Relation to patient: _____

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

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**Secondary Insurance (If Any):**_____

Policy #: _____ Group #: _____

Name of Primary Insured: _____Relation to patient: _____

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

**Preferred Pharmacy Information Pharmacy on file for medications and refills**

Name: _____ Phone #: _____

**I give permission for the following individuals listed below to be given information concerning my health and well being. Information may include appointments, test results, and medications.**

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

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 Medical Clinic has the right to refer my account to an outside collections agency after a period of 90 days.

_____

Signature

I hereby give authorization to all the physicians and staff at South Alabama Medical Clinic to treat my minor child or myself. I hereby give authorization for payment of insurance benefits to be made to South Alabama Medical Clinic for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. 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 any and all information necessary to secure payment of benefits and that a photocopy of this agreement shall be as valid as the original.

_____ _____ _____ _____

Signature (Patient or Responsible Party) Date Witness Date