Internal Medicine Associates of Middle Georgia

Patient Name: _____ **DOB**: ___ /___ /_____ **Gender**: ☐Male ☐Female

SSN: _____ **Race**: _____ **Ethnicity**: ☐Hispanic/Latino ☐Not Hispanic/Latino

Marital Status: _____ **Religion**: _____

Address: _____
(Street Address/PO Box) (City) (State) (Zip)

Phone: (home) _____ (work) _____ (cell) _____ (primary)_____

Email: _____ **Preferred Communication:** ☐Phone ☐Email ☐Mail

Employer: _____ **Status**: _____

Phone Number: _____

Emergency Contact: _____ **Relationship:** _____

Phone Number: _____ **DOB:** _____

Preferred "LOCAL" Pharmacy: _____ **City:** _____

Phone Number: _____

Mail Order Pharmacy: _____ **Phone:** _____

Insurance Information:

Primary Insurance Carrier: _____ **Policy #:** _____

Policy Holder Name: _____ **DOB:** _____

Secondary Insurance Carrier: _____ **Policy#:** _____

Policy Holder Name: _____ **DOB:** _____

Guarantor (If patient is a minor): _____ **DOB:** _____

Address (If different from patient): _____
(Street Address) (City/ State) (Zip)

Patient/Guardian Signature: _____ **Date**: _____

Updated 8/21/2014