EXPRESS CARE OF THE SHOALS.

PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Social Security Number: _____

Any physician, staff, employee or representative of Express Care of the Shoals/Medical Associates of the Shoals, P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons:

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT SIGNATURE: _____

DATE: _____

☐ **I do not want anyone to have access to my protected health information unless I provide explicit authorization.**

PATIENT SIGNATURE: _____

DATE: _____

IF ANY INFORMATION ON THIS FORM CHANGES, IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY EXPRESS CARE/MEDICAL ASSOCIATES IMMEDIATELY.

Express Care of the Shoals

PATIENT DEMOGRAPHICS

WHEN REGISTERING, PLEASE PRESENT PROOF OF INSURANCE. ALL COPAYMENTS AND OUT OF POCKET PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

PATIENT INFORMATION

LAST NAME / FIRST NAME / MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	
	- -	/ /	M F	S M W D	
ADDRESS	CITY	STATE	ZIP	HOME PHONE ( ) -	
SPOUSE'S NAME	PREFERRED PHARMACY			CELL PHONE ( ) -	
PREFERRED METHOD OF COMMUNICATION: HOME PHONE ☐ CELL PHONE ☐				WORK PHONE ( ) -	
RACE: WHITE (CAUCASION) ☐ BLACK (AFRICAN AMERICAN) ☐ AMERICAN INDIAN ☐ ASIAN ☐ OTHER ☐ I DECLINE TO LIST RACE ☐					
PRIMARY LANGUAGE: ENGLISH ☐ OTHER ☐	OCCUPATION (PATIENT):				

INSURANCE #1 (PRIMARY INSURANCE - THIS WILL BE FILED FIRST)

INSURANCE COMPANY	CONTRACT NUMBER			GROUP NUMBER	
SUBSCRIBER'S LAST NAME / FIRST NAME / MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
	- -	/ /	M F	S M W D	

INSURANCE #2 (SECONDARY INSURANCE - THIS WILL BE FILED AFTER PRIMARY INSURANCE PAYS)

INSURANCE COMPANY	CONTRACT NUMBER			GROUP NUMBER	
SUBSCRIBER'S LAST NAME / FIRST NAME / MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
	- -	/ /	M F	S M W D	

EMERGENCY CONTACT INFORMATION

LAST NAME / FIRST NAME	HOME PHONE	CELL PHONE	RELATIONSHIP TO PATIENT
ADDRESS	CITY	STATE	ZIP

FINANCIALLY RESPONSIBLE PARTY

THIS IS THE PERSON WHO ACCEPTS RESPONSIBILITY FOR PAYMENT OF THE ACCOUNT. THIS MAY OR MAY NOT BE THE SAME PERSON THAT HOLDS THE INSURANCE CONTRACT. ALL BILLING WILL GO TO THE FINANCIALLY RESPONSIBLE PERSON, AND THIS FORM MUST BE SIGNED BY THE PERSON WHO IS FINANCIALLY RESPONSIBLE.

LAST NAME / FIRST NAME / MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
	- -	/ /	M F	S M W D	
ADDRESS	CITY		STATE	ZIP	
EMPLOYER / EMPLOYER PHONE NUMBER	ADDRESS				

Insurance is a contract between you and your insurance company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-insurances, non-covered charges, pre-existing conditions, coordination of benefits, secondary insurance, or "reasonable and customary" charges, however, we will assist by filing your primary insurance and secondary insurance as a courtesy.

* I understand and realize that failure to make timely payment and maintain financial compliance is a basis for legal action and any court cost / collection fees / attorney fees will be assumed by me.

* I have read the financial policy and understand I am personally responsible for payment on this account in the event that my insurance deems a service to be "non-covered".

Signature - Financially Responsible (Guarantor)

Date

network drive: FORMS/PATIENT DEMOGRAPHICS

MEDICAL HISTORY

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH / /	SEX M F	MARITAL STATUS S M W D	SPOUSE'S NAME

ADDRESS	CITY	STATE	ZIP	HOME PHONE ( ) -

EMAIL	PREFERRED PHARMACY	CELL PHONE ( ) -

PREFERRED METHOD OF COMMUNICATION: HOME PHONE ☐ CELL PHONE ☐ MAIL ☐ EMAIL ☐	WORK PHONE ( ) -

PRIMARY LANGUAGE: ENGLISH ☐ OTHER ☐	EMPLOYER (PATIENT)	OCCUPATION (PATIENT)

CURRENT MEDICATIONS (including over-the-counter)

(1)	(6)
(2)	(7)
(3)	(8)
(4)	(9)
(5)	(10)

LIST ALL ALLERGIES (MEDICATION, FOOD, PLANT, OTHER)

(1)	(4)
(2)	(5)
(3)	(6)

SOCIAL HISTORY

DO YOU SMOKE ? YES NO	HAVE YOU EVER SMOKED YES NO	(if yes to either question): HOW MANY PACKS PER DAY? ____	FOR HOW MANY YEARS? ____

DO YOU DRINK ALCOHOL?	YES NO	1 - 7 DRINKS PER WEEK ☐	7 + DRINKS PER WEEK ☐
DO YOU OR HAVE YOU EVER ROUTINELY USED SMOKELESS TOBACCO?	YES NO	DO YOU OR HAVE YOU EVER USED PRESCRIPTION DRUGS RECREATIONALLY WITHOUT A DOCTOR'S ORDER OR PRESCRIPTION?	YES NO
DO YOU OR HAVE YOU EVER USED ILLEGAL "STREET" DRUGS? (Examples of this would be: Marajuana, Cocaine, Heroine, etc)			YES NO

CURRENT MEDICAL PROBLEMS (for which you are currently being treated)

(1)	(4)
(2)	(5)
(3)	(6)

DO YOU OR HAVE YOU EVER BEEN TOLD YOU HAVE HEPATITIS C, HEPATITIS B, OR HIV?	YES NO	IF YES: HEPATITIS C ☐	HEPATITIS B ☐	HIV ☐

SURGICAL HISTORY (Provide year and location of surgeries as this will help us locate your records)

SURGERY	LOCATION	YEAR	SURGERY	LOCATION	YEAR
(1)			(4)		
(2)			(5)		
(3)			(6)		

FAMILY HISTORY

HAS A BLOOD RELATIVE EVER HAD THE FOLLOWING:	CIRCLE APPROPRIATE		IF YES, CIRCLE ALL THAT APPLY			
HEART ATTACK	YES	NO	FATHER	MOTHER	BROTHER	SISTER
DIABETES	YES	NO	FATHER	MOTHER	BROTHER	SISTER
COLON CANCER	YES	NO	FATHER	MOTHER	BROTHER	SISTER
BREAST CANCER	YES	NO	FATHER	MOTHER	BROTHER	SISTER
OVARIAN CANCER	YES	NO	FATHER	MOTHER	BROTHER	SISTER
THYROID CANCER	YES	NO	FATHER	MOTHER	BROTHER	SISTER

TODAY'S ISSUE / PROBLEM:	