Alabama Medical Group, P.C.

Date:

Patient Information

SS#

Name (Last) (First)

Sex/Gender Male / Female

Date of Birth

Mailing Address

City State Zip

Home Number

Cell Number

Work Number

E-mail

Employer

Employment Status FT / PT / Retired / NA

Primary Care Physician

Emergency Contact

Name (Last) (First)

Home Number

Cell Number

HIPAA Contact

Name (Last) (First)

Home Number

Cell Number

Name (Last) (First)

Home Number

Cell Number

Other Contact

Name (Last) (First)

Home Number

Cell Number

I, ____, have received a copy of Alabama Medical Group, P.C. notice of Privacy and Rights and Responsibilities, as now required by Federal Law.

______________________________________ ________________

Signature of Patient/Legal Representative *Date*