Alabama Regional Medical Services
Patient Intake/Update Form

PATIENT INFORMATION					
Last Name	First Name	Middle Name			
Street Address	City	State	Zip Code		
Home Phone	Cell Phone	Race (Circle One)			
SSN #	Date of Birth	Asian	African American		
		Native American	American Indian/Alaska Native		
Female Male	Email Address	Native Hawaiian	Other Pacific Islander		
		White	More Than One Race		
Marital Status: Single Married Widow Divorced		Ethnicity (Check One)	Non-Hispanic	Hispanic	
Are you a veteran? ☐ Yes ☐ No	Public Housing Resident ☐ Yes ☐ No	How did you learn about ARMS?			
Are you homeless? ☐ Yes ☐ No		☐ Another doctor ☐ Radio ☐ TV ☐ Friend ☐ Health Fair			
☐ Shelter ☐ Transitional Housing ☐ Street		Preferred Method of contact? ☐ Mail ☐ Email ☐ Phone			

EMERGENCY CONTACT			
Name	Address	Phone Number	Relationship to Patient

EMPLOYER INFORMATION		
Place of Employment	Address	Work Phone

INSURANCE INFORMATION			
Primary Insurance		Secondary Insurance (if applicable)	
Name of Insurance Co		Name of Insurance Co	
Name of Policyholder		Name of Policyholder	
Policyholder DOB		Policyholder DOB	
Policy #		Policy #	
Group #		Group #	
Relationship to Patient		Relationship to Patient	

RESPONSIBLE PARTY INFORMATION			
Name	Address	Phone Number	Relationship to Patient

INCOME INFORMATION (Please complete to qualify for Sliding Fee Discount Program)					
Sources	Amount	Sources	Amount	Household Member(s)	
Employment	$	Retirement Pension	$	Name	
Public Assistance	$	Rental Income	$	Name	
Child Support, Alimony	$	Food stamps	$	Name	
Social Security Benefits	$	Other (please specify)	$	Name	
Total household income?		Total household size?			

I hereby certify that the above information is true and correct. I also agree to have any insurance payments assigned to Alabama Regional Medical Services.

Signature of Patient/Guardian:	Date:

Site:	Intake Completed by:	Patient #: