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
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	

Sexual Orientation (Circle One)	**Gender Identity (Circle One)**
Lesbian or Gay	Male
Straight (not lesbian or gay)	Female
Bisexual	Transgender Male/Female to Male
Something else	Transgender Female/Male to Female
Don't know	Other
Chose not to disclose	Chose not to disclose

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

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 #:

Revised 3/21/2017