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	How did you learn about ARMS? ☐ Another doctor ☐ Radio ☐ TV ☐ Friend ☐ Health Fair
SSN # / Date of Birth	
Email Address:	Preferred Method of contact? ☐ Mail ☐ Email ☐ Phone
Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced	Race: Asian Native American Native Hawaiian American Indian/Alaska Native Other Pacific Islander More than one Race African American White
Are you a veteran? ☐ Yes ☐ No / Public Housing Resident? ☐ Yes ☐ No	Ethnicity: Non-Hispanic Hispanic
Are you homeless? ☐ Yes ☐ No ☐ Shelter ☐ Transitional Housing ☐ Street	

Sexual Orientation (Select One)		Gender Identity (Select One)		Highest Level of Education	
Lesbian or Gay		Male		High School	
Straight (not lesbian or gay)		Female		GED	
Bisexual		Transgender Male/Female to Male		Less than high school	
Something else		Transgender Female/Male to Female		Some college/vocational	
Don't know		Other		College Degree	
Chose not to disclose		Chose not to disclose		Highest grade Completed	

EMERGENCY CONTACT			
Name	Address	Phone Number	Relationship to Patient

EMPLOYER INFORMATION		
Place of Employment	Address	Work Phone
Annual Income:	Household Size	

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:	ARMS Staff Signature:	Patient #:
		Revised: 2/4/2020