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  Ethnicity: Non-Hispanic Hispanic | | | | | | | | |
| Are you a veteran?  Yes  No | Public Housing Resident?  Yes  No | | | | |
| 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 | | | | | | | | | | | | | | |