Alabama Regional Medical Services

PATIENT INTAKE/UPDATE FORM

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| 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 WhiteEthnicity: 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 |
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| I hereby certify that the above information is true and correct. I also agree to have any insurance paymentsassigned to Alabama Regional Medical Services. |
| Signature of Patient/Guardian: | Date: |
| Site: | ARMS Staff Signature: | Patient #: |
| Revised: 2/4/2020 |