Patient Information

emc2care™
ALPHARETTA MEDICAL ASSOCIATES

PATIENT INFORMATION

PATIENT NAME ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. | LAST | FIRST | MIDDLE INITAL | SSN

BIRTH DATE | SEX ☐ Male ☐ Female | MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

HOME ADDRESS | CITY/STATE

ZIP CODE | HOME PHONE | WORK PHONE | ALTERNATE PHONE | CELL PHONE

EMAIL ADDRESS | WOULD YOU LIKE TO RECEIVE INFORMATION BY EMAIL? ☐ Yes ☐ No | EMPLOYER NAME AND ADDRESS

ARE YOU CURRENTLY TAKING 5 OR MORE MEDICATIONS? IF YES, PLEASE REQUEST AND COMPLETE A PATIENT MEDICATION CARD. ☐ Yes ☐ No

HOW DID YOU HEAR ABOUT EMC2CARE? ☐ Newspaper ☐ Friend ☐ Radio ☐ TV ☐ Direct Mail ☐ Physician Referral ☐ Other

WHOM SHOULD WE THANK FOR YOUR REFERRAL?

GUARANTOR INFORMATION

(PERSON FINANCIALLY RESPONSIBLE FOR BILLS AFTER INSURANCE COMPANY PAYMENT)

PLEASE CHECK BOX TO INDICATE IF INFORMATION IS SAME AS PATIENT: ☐ Same as Patient

GUARANTOR NAME | SSN

PATIENT'S RELATIONSHIP TO GUARANTOR: ☐ Self ☐ Spouse ☐ Dependent Child ☐ Student ☐ Other: ____________________

HOME ADDRESS | CITY/STATE

ZIP CODE | HOME PHONE | WORK PHONE

EMPLOYER NAME AND ADDRESS

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

INSURANCE ID NUMBER (MEMBER/CERTIFICATE) | PLAN NAME | PLAN NO. | GROUP NO.

SUBSCRIBER NAME | EFFECTIVE DATE

SSN | SUBSCRIBER D.O.B. | PRIMARY CARE PHYSICIAN

PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Dependent Child ☐ Student ☐ Other: ____________________

SECONDARY MEDICAL INSURANCE COMPANY

INSURANCE ID NUMBER (MEMBER/CERTIFICATE) | PLAN NAME | PLAN NO. | GROUP NO.

SUBSCRIBER NAME | EFFECTIVE DATE

SSN | SUBSCRIBER D.O.B. | PRIMARY CARE PHYSICIAN

PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Dependent Child ☐ Student ☐ Other: ____________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME | PHONE NUMBER