Stone Mountain Family Practice

PATIENT DATA
FORM MUST BE COMPLETED IN FULL

Name _____ Today's Date _____

Social Security #_____ Date of Birth _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced Gender ☐ Male ☐ Female

Home Address _____
Street City State Zip

Phone Numbers Home_____ Cell _____ Work _____

Primary Phone is ☐ Home ☐ Cell ☐ Work Reminder Call Made to ☐ Home ☐ Cell ☐ Work

Email_____ Preferred Contact Method ☐ Phone ☐ Mail ☐ Email

Preferred Language ☐ English Spanish Unknown ☐ Declined Other_____

Race ☐ American Indian/Alaskan ☐ Asian Black/African American ☐ White

☐ Native Hawaiian/ Other Pacific Islander ☐ Other Race ☐ Unknown ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

EMPLOYMENT

Employer _____ Dept./Title _____

EMERGENCY CONTACT

Spouse, companion, relative or friend living with you

Name & Relationship _____ Daytime Phone _____

Nearest relative or friend not living with you

Name & Relationship _____ Daytime Phone _____

INSURANCE INFORMATION

If you plan to use insurance for your medical services, you must present your current card before your visit. Otherwise, you will be asked to pay for services today and file your own insurance claim.

Primary _____ Policy # _____ Group # _____
Name of Insured & Relationship _____ DOB #_____

Secondary _____ Policy # _____ Group # _____
Name of Insured & Relationship _____ DOB #_____

PHARMACY INFORMATION

Please provide us with the local pharmacy you normally use to fill your prescriptions.

Pharmacy Name: _____

Address: _____

Phone #: _____

Over →