Alabama Digestive Disorders Center

NAME: _____ **Referring Dr.:** _____

Address: _____ **Date of Birth:** _____ Sex:_____

City,State,Zip: _____ **Marital Status:**_____

Home Phone: _____ **Social Security#:** _____

Cell Phone: _____ **Email Address:**_____

REMINDERS: May we leave messages for appointments, prescription refills or test results availability? ___Yes ___No
Preferred phone number for voice messages: ____Home Phone or ____Cell Phone or ____Work Phone
Preferred time for reminders: ____Morning (9 am – 12:00 noon) _____Afternoon (1 pm – 4 pm) ____Evening (6 pm – 8 pm)
May we send Text Message reminders to your cell phone: _____Yes ____ No

Employer
Name:_____

Address:_____**Work Phone:**_____
Employ Status: ____Full Time ____Part Time ____Retired ____Not employed **Student Status:** ____Full Time ____Part Time

Responsible
Party Name:_____ **Phone:**_____
(If other than patient)
Address:_____ **Relation:**_____

Employer:_____**Employer Address**_____

Emergency
Contact Name:_____ **Phone:**_____

Address:_____ **Relation:**_____

INSURANCE: Does your insurance require referral for office visits? _____ Yes _____No
What hospital does your insurance use? _____Any _____ Crestwood Medical Center _____Huntsville Hospital

Primary:_____ **Subscriber:**_____ **Group#:**_____

Insured:_____ **Relation:**_____ **Date of Birth:**_____/_____/_____

Second:_____**Subscriber:**_____ **Group#:**_____

Insured:_____ **Relation:**_____ **Date of Birth**_____/_____/_____

Other:_____ **Subscriber:**_____ **Group#:**_____

Insured:_____ **Relation:**_____ **Date of Birth:**_____/_____/_____

OTHER DATA: This information is being obtained to comply with Federal Regulations for Electronic Medical Records (may choose more than 1)
RACE: ____American Indian/Alaskan Native _____Native Hawaiian _____Asian ____Other Pacific Islander
____Black/African American _____Hispanic _____White ____Other Race ____Unreported

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ETHNICITY: (this is not same as Race) ___Hispanic or Latin American ___Not Hispanic or Latin American ___Unreported

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LANGUAGE: ___English ___Other ___Indian (includes Hindi & Tamil) ___Spanish ___Russian ____Unreported

Pharmacy
Name:_____ **Phone:**_____

Location:_____
I authorize Alabama Digestive Disorders Center, PC to electronically obtain my prescription history from external sources such as my pharmacy or insurance company.

Signature:_____ **Date:**_____