FAMILY MEDICINE ASSOCIATES
PATIENT INFORMATION SHEET

Date: _____ Preferred Pharmacy_____

NAME (First):_____ (MI) _____ (Last) _____

Sex: M F Birth Date: _____ Social Security No.:_____

ADDRESS: _____ CITY: _____ ST: _____ZIP:_____

HOME PHONE: _____WORK PHONE: _____CELL: _____

GUARANTOR (First): _____ (MI) _____ (Last) _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PRIMARY INSURANCE COMPANY: _____

SUBSRCIBER (First): _____ (MI) _____ (Last) _____

Sex: M F Birth Date: _____ Social Security No.: _____

Patient-Subscriber Relation: _____ Employer: _____

Effective from: _____ To: _____ ID#: _____

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER: (First) _____ (MI) _____ (Last) _____

Sex: M F Birth Date: _____ Social Security No.: _____

Patient-Subscriber Relation: _____ Employer: _____

Effective from: _____ To: _____ ID#: _____

EMERGENCY CONTACT: _____ PHONE: _____

Have you or any member of your family seen our doctors before? _____

Which Doctor _____ William B Whatley, III, MD _____ Brian E Rogers, MD
_____ J. Reed Cooper, MD _____ David L Adams, MD
_____ Dan M Guin, MD