

Diabetes And Endocrine Center Of MS

P O Box 2153 Dept 1975
 Birmingham, AL 35201-2153
 (601) 948-7313

PATIENT INFORMATION									
NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX	
LOCAL ADDRESS		CITY, STATE ZIP			REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS		ETHNICITY	
HOME PHONE	DAY PHONE	EMAIL ADDRESS			PRIMARY CARE PROVIDER	CITY, STATE ZIP		RACE	
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE		
PRIMARY EMPLOYER					SECONDARY EMPLOYER (if Applicable)				
ADDRESS					ADDRESS				
CITY, STATE ZIP					CITY, STATE ZIP				
WORK PHONE					WORK PHONE				

RESPONSIBLE PARTY INFORMATION (if Different than above)									
NAME (Last, First Middle)				SSN#	BIRTHDATE	LANGUAGE	SEX		
LOCAL ADDRESS		CITY, STATE ZIP			SECONDARY/BILLING ADDRESS (if Applicable)				
HOME PHONE	DAY PHONE	EMAIL ADDRESS			CITY, STATE ZIP				
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE			
RELATIONSHIP TO PATIENT									

PRIMARY INSURANCE									
NAME OF INSURANCE COMPANY					POLICY#				
NAME OF INSURED					GROUP#				
ADDRESS OF INSURANCE COMPANY					COPAY AMT \$				
CITY, STATE ZIP			PHONE		DEDUCTIBLE \$				
RELATIONSHIP TO PATIENT					EFFECTIVE DATE		EXPIRATION DATE		

SECONDARY INSURANCE (if Applicable)									
NAME OF INSURANCE COMPANY					POLICY#				
NAME OF INSURED			SSN#	BIRTHDATE	GROUP#				
ADDRESS OF INSURANCE COMPANY					COPAY AMT \$				
CITY, STATE ZIP			PHONE		DEDUCTIBLE \$				
RELATIONSHIP TO PATIENT					EFFECTIVE DATE		EXPIRATION DATE		

I authorize the release of any medical information that is necessary to process a claim to my insurance company. I will give the physician permission to release my medical records to any physician that is necessary for my treatment.

I have received a copy of DECM's Privacy Policy

I give my permission to release lab results or information regarding my health to: _____.

SIGNATURE OF PATIENT/GUARDIAN

DATE