

Montgomery Family Medicine  
8190 Seaton Place • PO Box 240389  
Montgomery, AL 38124

PATIENT REGISTRATION SHEET

DATE \_\_\_\_\_

PATIENT

LAST NAME FIRST NAME INITIAL ALLERGIES

ADDRESS CITY STATE ZIP

( ) ( )  
HOME PHONE CELL E-MAIL

SOC. SEC. NUMBER DATE OF BIRTH AGE

M  F  S  M  W  D  Sep  
SEX MARITAL STATUS IN AN EMERGENCY CALL PH. NUMBER

EMPLOYER WORK PHONE NUMBER

INSURANCE OR HEALTH PLAN INFORMATION

1.

PRIMARY INSURANCE CO. EFFECTIVE DATE GROUP NUMBER POLICY NUMBER

PRIMARY GUARANTOR (The name on the primary insurance card)

LAST NAME FIRST NAME INITIAL RELATIONSHIP

EMPLOYER SOC. SEC. NO. DATE OF BIRTH

2.

SECONDARY INSURANCE CO. EFFECTIVE DATE GROUP NUMBER POLICY NUMBER

SECONDARY GUARANTOR (The name on the secondary insurance card)

LAST NAME FIRST NAME INITIAL RELATIONSHIP

EMPLOYER SOC. SEC. NO. DATE OF BIRTH

You must sign our Financial Policy and a Consent to Treat and Release Information prior to treatment.  
You must present your insurance card at check-in and bring it with you to every visit.  
Our office may ask for your card to re-verify your coverage at anytime.  
Please keep us informed of any changes to your insurance coverage.