Southeast Medical Center / 3365 Skyway Drive, Suite 100 / Auburn, AL 36830
Office: (334) 539-1770 / Fax: (334) 539-1775 / www.southeastmedcenter.com

PATIENT INTAKE FORM

Instructions:Please fill in the form completely with blue or black ink.

Patient Information:

Date:_____

First Name: _____Middle Name: _____Last Name: _____

Email: _____SS#: _____

Street:_____City:_____State:_____Zip:_____

Home #:_____Cell #:_____Work#:_____

DOB_____Age:_____Gender:_____

Employer:_____Preferred guage:_____

Emergency Contact:_____Phone#:_____

Street:_____City:_____

_____

State:_____Zip:_____Relation to Patient:_____

Preferred Pharmacy: _____ Phone: _____

Primary Insurance:

Insurance Plan Name:_____Effective From:_____

Address:_____City:_____

State:_____Zip_____Phone #:_____

Insurance ID:_____Group ID:_____

Copay:_____Relation to Insured:_____

Subscriber Name:_____DOB:_____Gender:_____

Secondary Insurance: (if applicable)

Insurance Plan Name:_____Effective From:_____

Address:_____City:_____

State:_____Zip_____Phone #:_____

Insurance ID:_____Group ID:_____

Copay:_____Relation to Insured:_____

Subscriber Name:_____DOB:_____Gender:_____

Preferred Pharmacy: _____Phone: _____

Signature: _____