Shelby OB/GYN P.C.

DATE: _____

Please check the location seen at:

__ Main Office-Alabaster __ Clanton Office __ Hoover Office

Please check the physician you are seeing:

__Dr. James L. Head __Dr. George M. Zaharias __Dr. E. Malcolm Simmons, III
__ Dr. Ashley J Gooding __ Dr. Kara M. Conti __ Dr. Jessica L. Rodriguez

Patient Info

FULL Name: Last_____First_____Middle_____

Preferred 1st Name: _____ **Maiden Name**: _____ **DOB**: _____ **AGE**: _____

SS#: _____ **Marital Status:** __single __ married __divorced __ separated __ widowed
RACE: __American Indian\Alaskan Native __Asian __Black\African American __ White\Caucasian
__Native Hawaiian\Pacific Islander __ Mexican __Other Race: _____
Ethnicity---Hispanic\Latino: __Yes or __No **Primary Language**: __English __Spanish __Other:_____
Religion: __Catholic __Islam __Jewish __Protestant (eg Baptist, Methodist) __Other: _____
Drivers License#: _____\ST_____ OR Other ID#:_____ TYPE:_____

Address (No PO Box): _____City: _____ State: ____ Zip: _____
Billing Address if different from above: _____
Phone #'s: Home: _____ Work #:_____Cell#:_____
Fax: _____ **EMAIL**: _____
Check: __Retired __ Housewife __Student (Circle: Full or Part-time) **School**: _____
__Employed (Circle: Full or Part-time) **Employer**: _____

Associated Party Info

Spouse's Name:_____ Suffix (ie Jr.): ____ DOB:_____ SS#: _____
Employer:_____ Work#:_____ Cell#: _____

Person to notify in case of emergency:_____ PH#:_____
Relationship to PT: __Significant Other __FOB ___Guardian __Friend __Relative (type):_____

Person responsible for account (if pt under 19):_____ DOB:_____
Address:_____ Home#: _____
Employer:_____ W#:_____ Drivers License#:_____
Relationship to PT: _____ SS#: _____ Cell#: _____

Insurance Information: Please present ALL cards

Insurance Company (**Primary**):_____ **COPAY: $** _____
Contract#_____ **Group#: _____**
Policy Holder's name: _____ **Birth date:** _____
Address: _____ Relationship to Pt: _____
SS#: _____ Employer**:** _____ W#: _____ Cell#: _____

Insurance Company (**Secondary**) _____ **Contract#_____**
Group#_____ Policy Holder's name: _____ **Birth date:**_____
Address: _____ Relationship to PT: _____
SS#: _____ Employer:_____ Work#: _____ Cell#:_____

I was Referred by:_____ AND\OR Primary Care Dr:_____

Preferred Method of Payment: __CASH __CHECK __DEBIT CARD __ CREDIT CARD __FLEX CARD