

Patient Information

Dr. Stephen Trammell
Board Certified Family Practice AOA

Patient Name Date of Birth

Home Address _____ APT# _____ Gender: Male / Female

City & State _____ Zip _____ Marital status _____

Home # _____ Cell _____

Social Security Number _____

Drug Allergies: _____

Responsible Party: We need a copy of your picture ID and copy of insurance card, if applicable
This must be completed in full for us to properly set up your account and process your paperwork. We have to keep a picture ID on file for accepting checks.

Responsible Party/Insured Member _____ DOB _____

Social Security # _____ Relationship to patient _____

Employer _____ Work # _____

Occupation _____ Cell # _____

Spouse's name _____ DOB _____

SS# _____ Relationship to patient _____

Employer _____ Work # _____

Occupation _____ Cell # _____

BE SURE TO KEEP THIS OFFICE INFORMED OF ANY CHANGES IN RESPONSIBLE PARTY, ADDRESS, CONTACT NUMBERS OR INSURANCE. SHOULD ANYTHING CHANGE, PLEASE REMEMBER, YOU ARE RESPONSIBLE FOR NOTIFYING THIS OFFICE OF THESE CHANGES.

Patient Signature

Date

IF THIS PATIENT IS A MINOR, WE NEED CONSENT TO TREAT AND SIGNED BY PARENT/GUARDIAN

I give my consent for the office of Dr. Trammell to treat the above stated minor child that I am responsible for as the adult guardian or parent.

Parent / Guardian Signature

Relationship to minor

Date