

Dr. T. Mark Ricketts, MD

Board Certified in Internal Medicine
Masters of Public Health
Fellow of the American College of Physicians
Master of the American Academy of Cardiology

Patient Information

Name: _____ Email: _____
(first) (last)

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____
(home) (cell)

SSN: _____ Date of Birth: _____ Sex: M ___ F ___

Employer: _____ Work Phone: _____

Emergency Contact: _____
(Name) (relationship) (phone number)

Who referred you to Dr. Ricketts? _____

Insurance: _____
(company) (contract number) (group number)

Policy Holder (PH) (if different from patient): _____

PH Date of Birth: _____ PH SSN: _____

Relationship of patient to Policy Holder: ___ Self ___ Spouse ___ Dependent

Secondary Insurance: _____
(company) (contract number) (group number)

Policy Holder (PH) (if different from patient): _____

PH Date of Birth: _____ PH SSN: _____

Relationship of patient to Policy Holder: ___ Self ___ Spouse ___ Dependent

Medications (please list all CURRENT medicines, dosages & strengths): _____

Please turn page over to complete >

Allergies (please list all DRUG allergies) : _____

Pharmacy for your prescriptions to be sent: (Please give specific name, location & phone number)

The healthcare reform act requires all medical providers to report statistically the following information.

Preferred language of communication: (please check one)

English _____	Japanese _____
Arabic _____	Korean _____
Filipino _____	Polish _____
French _____	Portuguese _____
German _____	Russian _____
Greek _____	Spanish _____
Hindi _____	Vietnamese _____
Italian _____	Other _____

Race: (please check one)

American Indian / Alaska Native _____	White _____
Asian _____	Other Race _____
Black _____	Unknown _____
National Hawaiian / Pacific Islander _____	Declined _____

Ethnicity: (please check one)

Hispanic or Latino _____
Not Hispanic or Latino _____
Unknown _____
Declined _____

Tobacco Use: (please check one)

Current (every day) _____
Current (some days) _____
Former _____
Never _____

Patient Payment & Insurance Agreement

I (we) the undersigned, hereby agree to pay all amounts and charges hereafter incurred by me and by members of my family for services rendered. Failure to make payment when requested is basis for a legal action. The undersigned agrees to pay all costs of collection and hereby waive(s) his/her right of exception under the laws of the state of Alabama and any other state(s). All legal collection will be handled by designated agent(s) of T. Mark Ricketts, M.D., including but not restricted to The Merchants Credit Association.

THE PATIENT IS RESPONSIBLE FOR ANY EXPENSES THEIR INSURANCE DOES NOT COVER.

Co-payment is required at the time of service. If you do not have insurance, payment is required at the time of service. If you do have insurance and provide us with accurate, current information, we will assist you in obtaining insurance payment.

(Patient / guardian signature)

Date