Welcome to Alpharetta Family Medical Clinic

Please Complete Sign-In Sheet

Date _____ Time _____

Name of Patient _____
First MI Last Name Called

Address : _____
Street Number and Name

_____
City State Zip Code

Date of Birth _____ SSN _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell ( ) _____ e-mail _____

If Patient is a minor, Name of Parent or Guardian _____

Male Female Marital Status (circle one) S M D W

Spouse's Name _____

Person to contact in case of Emergency :

Name _____ Phone _____ Relationship _____

Name of Insurance Company _____

No Insurance/ Self Pay _____

How did you hear about us? _____

In case my insurance carrier denies the payment, I agree to be fully responsible for the full payment of the medical service received at Alpharetta Family Medical Clinic.

_____ _____
Signature Date

*** Please provide receptionist with your insurance card upon checking in so that we can make a copy for your chart.*