REFORM MEDICAL CENTER, PC

H. LEE RICHARDSON, M.D.
Family Practice

514 Tenth Ave SW
PO Box 670
205-375-9064
Reform, AL 35481

Ph: 205-375-6251
Fax:

PATIENT REGISTRATION ON MEDISYS

Please Print
NAME:

_____
Last First Middle

ADDRESS:

_____
Mailing Address City State Zip Code

**At least two (2) contact numbers are required. If you list any number other than your own, you must by state law add that person to your HIPAA name list.*

TELEPHONE*: _____
Home

_____
Work

_____
Cell

_____ _____
Other Name

SS#: _____ **DATE OF BIRTH:** _____ **AGE:** _____

GENDER: ___ Male ___ Female **MARITAL STATUS:** ___ Single ___ Married ___ Divorced ___ Widowed

HEALTH INFORMATION: **Do you smoke: Y__ N__ Drink: Y__ N__ Any Allergies: Y__ N__ If yes, please list:_____**
_____ **Health problems or past illnesses?**
_____
_____
Hospitalizations/Surgeries:
_____

Family History: Heart disease___ Hypertension___ Diabetes___ Cancer___ Asthma___
Other:_____

Medications: _____

~ PLEASE PROVIDE INSURANCE CARDS (for copies) FOR ALL INSURANCE ~