

PHYSICIAN \_\_\_\_\_ CHART# \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City Zip

PREVIOUS ADDRESS \_\_\_\_\_  
(If less than 2 years at current address)

HOME PHONE \_\_\_\_\_ SS# \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ MARITAL STATUS M S W SEP D SEX: M or F  
(Please Circle One)

CELL PHONE \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

HOW OFTEN DO YOU CHECK YOUR E-MAIL?  DAILY  WEEKLY  MONTHLY  RARELY

WHOM MAY WE THANK FOR REFERRING YOU TO US? \_\_\_\_\_

GUARANTOR (Person responsible for payments) \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_  
Name of Insurance ID# and/or SS#

Card Holder's Name Employer Group or Policy #

SECONDARY INSURANCE \_\_\_\_\_  
Name of Insurance ID# and/or SS#

Card Holder's Name Employer Group or Policy #

IF PATIENT IS A CHILD, IS CHILD COVERED BY BOTH PARENTS INSURANCE?

Father's Insurance \_\_\_\_\_ Father's Date of Birth \_\_\_\_\_

Mother's Insurance \_\_\_\_\_ Mother's Date of Birth \_\_\_\_\_

PLEASE COMPLETE THE FOLLOWING INFORMATION SO WE WILL HAVE A SECOND TELEPHONE NUMBER SHOULD WE NEED TO REACH YOU. SOME INSURANCE COMPANIES REQUIRE THIS INFORMATION ALSO.

YOUR EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

SPOUSE'S SS# \_\_\_\_\_ SPOUSE'S BIRTHDAY \_\_\_\_\_

NAME OF RELATIVE OR FRIEND NOT LIVING WITH YOU \_\_\_\_\_  
PHONE \_\_\_\_\_

"I understand I am responsible for all the charges (fees) for services rendered to me or my family. If I have health insurance it is my responsibility to see to it my health insurance policy pays the benefits provided under said policy. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, the Department of Social Services or its contractor, Blue Cross and Blue Shield of South Carolina, and any commercial insurance company any such information needed for this or a related Medicare, Medicaid, Blue Shield, or any commercial insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment on this claim."

DATE \_\_\_\_\_  \_\_\_\_\_  
Patient's or Authorized Person's Signature

**NOTE: PLEASE PRESENT YOUR INSURANCE CARDS AND DRIVER'S LICENSE TO THE RECEPTIONIST.**