

PHYSICIAN _____ CHART # _____

NAME _____ DRIVER'S LICENSE _____

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)

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 #

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 _____

YOUR 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 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.