

PATIENT INFORMATION RECORD

Last Name		First Name			Middle Init
Social Security #				Circle One: Mr. Mrs. Ms. Miss Dr.	
Street Address				Apt/Lot#	
City		State	Zip	DOB	
Home Phone			Cell Phone		
Sex	M	F	Race	Marital Status	S M W D
			Student? Yes No Full-time Part-time		
Employment Full-time Part-time Retired Disabled				Email Address	
Hospice / Skilled Nursing Facility			Y	N	Facility Name
Referring Physician				Phone Number	
Primary Care Physician				Phone Number	
Spouse				Phone Number	
Emergency Contact				Relationship	
Phone Number				Cell Phone	

Primary Insurance		
Policy Holder Name	DOB	SSN
Policy Number	Group #	Group Name

Secondary Insurance		
Policy Holder Name	DOB	SSN
Policy Number	Group #	Group Name

Consent for Treatment, Payment, and Acknowledgement of Receipt of Notice of Privacy Practices: I request that payment under the medical insurance program be made payable to Lowcountry Rheumatology for services rendered. I understand that I am financially responsible for all charges incurred at Lowcontry Rheumatology. I authorize disclosure of my personal health information to carry out treatment, payment, or health care procedurés. I have received the privacy policy and Notice of Information Practices that provides a more complete description of information uses and disclosures. I agree to pay any and all charges that exceed or not paid/covered by my insurance. In the event my account is turned over to a collection agency, I will be billed the additional collection fees.

Patient / Guardian: _____
Signature

Print Name

Date

Witness

Date