

ACCT# _____

PATIENT INFORMATION RECORD

Date _____

Social Security # _____

Circle One: Mr. Mrs. Ms. Miss Dr. Last Name: _____ First Name: _____ MI _____

Address: _____ Apt/Lot #: _____

Zip code: _____ City: _____ State: _____

Home Phone: _____ Cell or Pager: _____

Birth date: _____

Circle one of each

Sex: _____ Race: _____ Marital: S M W D

Are you a student? No Yes Full P/T

Employment: Fulltime Part-time Retired Disabled

Referring Physician: _____ Phone Number: _____

Primary Doctor: _____ Phone Number: _____

Your Employer _____ Phone (____) _____ May we call you at work _____

Spouse's Name _____ Phone (____) _____

Whom do we contact in case of an emergency: _____ Relationship to you: _____

Phone #: _____ Cell: _____

Insurance Information*Primary Insurance*

Who is your primary health insurance? _____

Name: _____ D.O.B. _____ SSN: _____

Policy #: _____ Group #: _____ Group Name: _____

Secondary Insurance

Who is your secondary health insurance? _____

Name: _____ D.O.B. _____ SSN: _____

Policy #: _____ Group #: _____ Group Name: _____

Insurance Authorization

I hereby authorize Low Country Rheumatology (LCR) to apply to my insurance company for benefits on my behalf for covered services rendered by their facility. I request payment to be made directly to LCR on my behalf. I realize that I am responsible for full payment of charges not paid by my insurance company.

I hereby authorize LCR to release medical information to any physician or insurance company involved in my care. I certify that this information is correct and complete.

Date _____ Signature _____