Low Country Rheumatology, A Member of Articularis Healthcare, Inc.
Patient Information

Last Name	**First Name**	**Middle Initial**
Street Address		**Apt/Lot**
City	**State**	**Zip**
SSN	**DOB**	**Circle One:** ◯ **Mr.** ◯ **Mrs.** ◯ **Ms.**
Email	**Cell #**	**Home #**
Circle One: ◯ **Male** ◯ **Female**	**Marital Status** ◯ **S** ◯ **M** ◯ **W** ◯ **D**	**Student** ◯ **Yes** ◯ **No**

Employment (Circle One):
◯ **Full-Time** ◯ **Part-time** ◯ **Retired** ◯ **Disabled**

Referring Physician	**Phone #**
Primary Care Physician	**Phone #**
Spouse	**Phone #**
Emergency Contact	**Phone #**
Primary Insurance Name	**Policy #**
Policy Holder Name	**DOB**
Group #	**Group Name**
Secondary Insurance	**Policy #**
Policy Holder Name	**DOB**
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 Articularis Healthcare Group, Inc. I authorize disclosure of my personal health information to carry out treatment, payment or health care procedures. 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: _____ Date: _____
Signature