



1 WELLNESS BOULEVARD, # 200  
 IRMO, SOUTH CAROLINA 29063  
 PHONE: (803) 749-1111  
 FAX: (803) 749-0050

**PATIENT INFORMATION**  
 (PLEASE PRINT)

<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss		Patient's Last Name:		First:		Middle Initial:	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid			Nickname:		Birth/Maiden Name:		
Birth Date:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	SSN:		Email Address:		
Preferred Language:	Race:		Ethnicity:		Driver's License Number:	State:	Exp. Date:
Home phone:		Work phone:			Cell phone:		
Address:			City:		State:	ZIP Code:	
Occupation:		Employer & Address:			Employer phone:		
Referred to practice by:		<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Patient _____		<input type="checkbox"/> Other _____	
May we include your name on the thank you letter we send to the person who referred you to our practice? <input type="checkbox"/> Yes <input type="checkbox"/> No							

**INSURANCE INFORMATION**  
 (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill: (if self, please skip to Primary Insurance)			Is this person a patient at our practice? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Birth:	Address:		Home Phone:		
Occupation:	Employer & Address:		Employer phone:		
<b>**Policy Holder's Name, SSN, Date of Birth and Relationship to Patient are <u>REQUIRED</u> to file all insurance claims.**</b>					
<b>Primary Health Insurance Company:</b>					
*Policy Holder's Name:(as it appears on insurance card)			*SSN:		*Birth date:
Group Number:		Policy Number:		Co-Payment: \$	
*Patient's relationship to Policy Holder:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
<b>Secondary Health Insurance Company:</b>					
*Policy Holder's Name:(as it appears on insurance card)			*SSN:		*Birth date:
Group Number:		Policy Number:		Co-Payment: \$	
*Patient's relationship to Policy Holder:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

**IN CASE OF EMERGENCY (LOCAL FRIEND/ RELATIVE)**

Name:	Relationship:	Phone #:	Alt. Phone #:
Name: (not living at same address)	Relationship:	Phone #:	Alt. Phone #:

*The above information is true to the best of my knowledge. I authorize South Carolina Internal Medicine Associates & Rehabilitation, LLC (SCIM) or insurance company to release any information required to process my claims. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand payment is due at time of service, and that SCIM reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections.*

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_