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PATIENT INFORMATION
 (PLEASE PRINT)

| | | | | | | | |
|---|--|--|-------------|--|-----------------|--------------------------------------|--|
| <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. | | Patient's Last Name: | | First: | | Middle Initial: | |
| <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss | | | | | | | |
| 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: | | |
| Driver's License Number: | | | | State: | | Expiration 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: | | |
| **Policy Holder's Name, SSN, Date of Birth and Relationship to Patient are REQUIRED to file all insurance claims.** | | | | | | | |
| Primary Health Insurance Company: | | | | | | | |
| *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: _____