



SOUTH CAROLINA INTERNAL MEDICINE ASSOCIATES AND REHABILITATION, L.L.C.

REGISTRATION FORM PATIENT INFORMATION (PLEASE PRINT)

Patient's last name:		First:			Middle Initial:	
Prefix: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	Suffix: <input type="checkbox"/> , I <input type="checkbox"/> , II <input type="checkbox"/> , III <input type="checkbox"/> , Jr. <input type="checkbox"/> , Sr.	Name you prefer to be called:			Birth/Maiden Name:	
Birth Date:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	SSN:	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid	Driver License Number:	Expiration Date:	State:
<input type="checkbox"/> Home phone:	<input type="checkbox"/> Work phone:	Ext:	<input type="checkbox"/> Cell phone:	Please check the box beside the phone number you would prefer our practice to call.		
Address:			City:	State:	ZIP Code:	
Occupation:		Employer:			Employer phone:	
Referred to our 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)		Birth date:	Address (if different):		Home phone:
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:		Employer phone:	
Please indicate Primary Insurance:					
*Policy Holder's Name, SSN, Date of Birth and relationship to patient are required to file all insurance claims.					
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

Name of local friend or relative:	Relationship to patient:	Home phone :	Work phone:	Cell phone:
Name of local friend or relative: (not living at same address)	Relationship to patient:	Home phone:	Work phone:	Cell 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