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**PATIENT INFORMATION**  
 (PLEASE PRINT)

Patient's Last Name:		First:	Middle:		
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss	Name you prefer to be called:		Birth/Maiden Name:		Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid
Birth Date:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	SSN:	Driver's License Number:	Exp 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 #:		E-mail address:		
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>Please indicate Primary Insurance:</b>					
<b>*Policy Holder's Name, SSN, Date of Birth and relationship to patient are required to file all insurance claims.</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**

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: \_\_\_\_\_