

# Palmetto Family Medicine of Columbia, P.A.

## Patient Demographics

Date	<b>PATIENT INFORMATION</b>				Account Number
Last Name	First Name	MI	Date of Birth	Age	
Street Address		Apartment # or Second Address Line			
City	State	ZIP	Email Address		
Home Phone	Work Phone	Extension	Cell Phone		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Social Security # (Required)		
Employment <input type="checkbox"/> Retired <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> None	Employer/School Name			Job Title	
Student <input type="checkbox"/> Full <input type="checkbox"/> Part	Employer/School Address				
<b>INSURANCE INFORMATION</b>					
Primary Insurance Company Name			Insured's Employer		
Name of Insured	Date of Birth	Social Security # (Required)	Relationship to Patient		
Group		Policy/ID #			
Spouse's Name	Social Security #	Date of Birth	Work Telephone	Job Title	
Spouse's Employer and Address					
Secondary Insurance Company Name			Insured's Employer		
Name of Insured	Date of Birth	Social Security #	Relationship to Patient		
Group		Policy/ID #			
<b>OTHER INFORMATION</b>					
Please List any Drug Allergies					
In Case of Emergency Call:		Relationship to Patient		Telephone	
How Did You Hear About Our Practice?					
<b>Authorization to Release Information</b> I hereby authorize Palmetto Family Medicine of Columbia to release any medical information necessary to process insurance claims and to continue medical treatment here or with a referred specialist and certify that the above information is correct.			<b>Authorization to Pay Benefits</b> I hereby authorize and assign direct payment to Palmetto Family Medicine of Columbia of surgical and medical benefits. I understand that I am financially responsible for charges not covered by this assignment.		
Signed _____ (Insured Person)			Signed _____ (Patient or Responsible Person)		

**Financial Agreement: Copayments must be made at time of visit. If not paid at time of service a \$25 billing fee will be applied.**

**Signature:** \_\_\_\_\_

**Financial & Privacy Practices: I have received a copy of Palmetto Family Medicine's Policies.**

**Signature:** \_\_\_\_\_