Palmetto Family Medicine of Columbia, P.A.

PATIENT INFORMATION

Date			Account Number	
Last Name	First Name	M I	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 ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			Social Security # (Required)	
Employment ☐ Retired ☐ Full ☐ Part ☐ None	Employer/School Name			Job Title
Student ☐ Full ☐ Part	Employer/School Address			

INSURANCE INFORMATION

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 #		

OTHER INFORMATION

Please List any Drug Allergies		
In Case of Emergency Call:	Relationship to Patient	Telephone
How Did You Hear About Our Practice?		

Authorization to Release Information

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.

Signed (Insured Person)

Authorization to Pay Benefits

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 (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: ____________________