Physician _____ **Chart Number** _____

Patient Information

Palmetto OB-GYN Associates | PALMETTO HEALTH PHYSICIAN PRACTICES

Patient Name (first, middle, last) _____ SSN _____

Birth Date _____ Sex ☐M ☐F Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Life Partner

Address _____ City/State/Zip _____

Phone: Home _____ Cell _____ Work _____

Email _____

Ethnic Origin ☐Native American ☐Asian ☐Black ☐Hispanic ☐White ☐Other Primary Language _____

Primary Care Doctor/Referring _____

Military Pay Grade _____ ☐Active Duty ☐Retired Military Branch _____

Emergency Contact Information

Name _____

Relationship to Patient _____ Phone Number _____

Guarantor Information (Financially Responsible Party) ☐Check if information is same as above

Name (first, middle, last) _____ SSN _____

Birth Date _____ Sex ☐M ☐F Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Life Partner

Address _____ City/State/Zip _____

Phone: Home _____ Cell _____ Work _____

Guarantor's Relationship to Patient _____

Guarantor Employer Information (Financially Responsible Party)

Employer Name _____ Occupation _____

Address _____ City/State/Zip _____

Primary Insurance Information

Policy Holder _____ Sex ☐M ☐F

Policy Holder's Relationship to Patient _____ Policy Holder's SSN _____

Policy Holder's Birth Date _____ Policy Holder's Phone Number _____

Policy Holder's Address _____ City/State/Zip _____

Insurance Company _____ Effective Date _____

Group# _____ Policy/Certificate ID# _____

Insurance Company Address _____

Secondary Insurance Information ☐Check if you do not have Secondary Insurance

Policy Holder _____ Sex ☐M ☐F

Policy Holder's Relationship to Patient _____ Policy Holder's SSN _____

Policy Holder's Birth Date _____ Policy Holder's Phone Number _____

Policy Holder's Address _____ City/State/Zip _____

Insurance Company _____ Effective Date _____

Group# _____ Policy/Certificate ID# _____

Insurance Company Address _____

Release Information

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I request that payment of authorized Medicare benefits be made to my physician.

_____

Signature of Patient (Parental Signature if Minor) Date