

CAROLINA MEDICAL ASSOCIATES

PATIENT INFORMATION SHEET

How did you hear about us? ___Advertisement ___Insurance Company ___Friend/Family

TODAYS DATE_____

SOCIAL SECURITY #_____DATE OF BIRTH_____

DRIVERS LIC #_____SEX_____

PATIENT NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE#_____WORK#_____

EMPLOYER_____OCCUPATION_____

EMPLOYERS ADDRESS_____CITY_____STATE_____ZIP_____

REFERRING PHYSICIAN_____CITY/ST_____

EMERGENCY CONTACT_____RELATION_____PHONE_____

INSURANCE INFORMATION:Please present card to front desk!

METHOD OF PAYMENT CASH___CHECK___MASTERCARD/VISA_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF MEDICAL BENEFITS, IF APPLICABLE, OTHERWISE PAYABLE TO ME, FOR SERVICES RENDERED. I RECOGNIZE AND ACCEPT PERSONAL RESPONSIBILITY FOR ANY BALANCE REMAINING, INCLUDING COLLECTION FEES, AFTER PAYMENT OF SUCH BENEFITS.

SIGNATURE OF RESPONSIBLE PARTY_____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE CLAIMS:

I HEREBY AUTHORIZE THE DESIGNATED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT IN ORDER TO PROCESS INSURANCE CLAIMS, IF APPLICABLE.

SIGNATURE_____

CONSENT TO USE SIGN-IN SHEET:

I HEREBY AGREE TO LIST MY NAME ON THE SIGN-IN SHEET AT THE FRONT DESK. IF I ELECT NOT TO SIGN MY NAME, I MUST ENTER MY ACCOUNT NUMBER. I UNDERSTAND IT IS MY RESPONSIBILITY TO KNOW MY ACCOUNT NUMBER IF I CHOOSE THAT OPTION.

SIGNATURE_____