



9291 Medical Plaza Drive ❖ N. Charleston, SC 29406 ❖ 797-3664

PATIENT INFORMATION

SPOUSE OR PARENT INFORMATION

(Circle One)

Name _____
Last First Middle Int.

Race _____ Marital Status M S D W (circle)

Address _____
Street Apt.

City _____ State _____ Zip _____

Date of Birth _____

Social Security # _____

State Driver's License # _____

Referred by: _____

Home Phone _____ Work _____

Cell Phone _____ Fax _____

Email _____ Pager _____

Employer Name _____

Address _____
Street of P.O. Box Suite #

City _____ State _____ Zip _____

*** IF YOU HAVE ANY QUESTIONS
 PLEASE BRING THEM TO OUR ATTENTION ***

Name _____
Last First Middle

Address _____
Street Apt.

City _____ State _____ Zip _____

Social Security # _____

Date of Birth _____

Employer Name _____

Address _____
Street or P.O. Box

City _____ State _____ Zip _____

Home Phone _____ Work _____

****NEAREST RELATIVE OR FRIEND NOT LIVING
 WITH YOU FOR AN EMERGENCY**

Name _____
Last First Relation

Address _____
Street Apt.

City _____ State _____ Zip _____

Phone# _____

All professional services rendered are charged to the patient. If surgery or in-office surgical procedures are indicated, the patient is responsible for furnishing insurance claims to the office prior to surgery. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. If this account has to be turned over for collection, the undersigned guarantor (parent or guardian if, patient is a minor) agrees to pay interest of 18% and all collection and attorney's fees.

Our office policy is not to release medical records directly to patients. We will gladly forward copies of records to another physician or hospital upon receipt of a written request. If records must be released directly to patients, at least five (5) working days prior notification is required in writing, and the patient will have to pay record release charges when request is made.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT.

Signature

Witness

Date: _____

Date: _____

MEDICAL INSURANCE INFORMATION

(1) PRIMARY Insurance Company _____ Phone _____

Mailing Address for Claims _____
Street or P.O. Box City State Zip

Is insurance through employer? _____ POLICY # _____

If Yes, Employer Name _____

Name of Insured _____ SOC. SEC. # _____

Insured's Date of Birth _____ GROUP # _____

Relationship to Insured _____

(2) SECONDARY Insurance Company _____ Phone _____

Mailing Address for Claims _____
Street or P.O. Box City State Zip

Is insurance through employer? _____ POLICY # _____

If Yes, Employer Name _____

Name of Insured _____ SOC. SEC. # _____

Insured's Date of Birth _____ GROUP # _____

Relationship to Insured _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Low Country Women's Specialists, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. I certify that the above information is true and correct.

I understand that I am to IMMEDIATELY notify Low Country Women's Specialists if ANY changes occur in my insurance.

Signature

Date

Signature

Date

Signature

Date

Signature

Date