Patient Information

Palmetto Tri-County Primary Care
201-A West Meeting Street
Lancaster, SC 29720
803-286-4666 / FAX: 803-285-1585

PATIENT

NAME:	LAST	FIRST	MIDDLE	*NICKNAME* */PREFERRED NAME
Birthday:		Sex: M / F	Civil Status: S / M / D / W	SS#:
Home Address:	STREET	CITY	STATE	ZIP-CODE
Home Phone:	( )	Work Phone:	( )	Driver's License:
(Office Use)	( )	(Office Use)	( )	
Employer:		Occupation:		

GUARDIAN

Please fill out the following information if patient is a minor or student.			SS#:
NAME:		Relationship:	
Address *(If different)*	☐ Same STREET	CITY	STATE ZIP-CODE
Home Phone:	( )	Work Phone: ( )	Driver's License:
Employer:		Occupation:	
Work Address:	STREET	CITY	STATE ZIP-CODE

INSURANCE

		COVERAGES and BENEFITS:	
Primary Carrier:			
Name of Insured:		Co-Pay:	$ or %
Relationship to Patient:	Self Spouse Father Mother	Deductible:	$ per year
Insured's I.D.#:		Physicals?	NO 1 per year 1 per 2 yrs
Insured's Date of Birth:		Hepatitis B?	Yes No If indicated
Group# / Company Name:		Hepatitis A?	Yes No If indicated
Effective Date:		Immunizations?	Yes No If indicated
Primary Care Physician:		Obesity?	Yes No If indicated

ACKNOWLEDGEMENT OF RESPONSIBILITY:
I acknowledge that I am ultimately and personally responsible for this account. Even though this office may file my insurance and verify eligibility, this is not a guarantee of payment by the insurance company for any services that I may receive. I assume full responsibility for any non-covered services, deductibles, or co-payments that my insurance company does not pay.

Signature of Insured Person _____ Date/Time _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize my insurance company to make direct payment to the physician and or the office for any medical services rendered by him or under his supervision.

Signature of Insured Person _____ Date/Time _____

AUTHORIZATION TO PHOTOGRAPH:
I agree to allow the physician or his staff to photograph me (or my legal charge/child) for the purposes of the medical record. I understand that such photographs will never be used in any way which would reveal my personal identity.

Signature of Insured Person _____ Date/Time _____

AUTHORIZATION TO RELEASE INFORMATION:
I agree to allow the physician or his staff to release to my insurance company any information necessary to secure payment for services rendered.

Signature of Insured Person _____ Date/Time _____