MON.–THURS. 8:00-1:00,
2:00-5:00
FRI. 8:00-12:00

PATIENT ACCOUNT NUMBER_______________

DATE_____________

Welcome to the SFM Family

LAST NAME ____________________ FIRST NAME ________________ MI ____

DATE OF BIRTH____________________ AGE _______ SEX_______ RACE_______

HOME ADDRESS______________________________CITY_____________STATE_______ZIP__________

HOME PHONE________________CELL PHONE_________________BUSINESS PHONE________________

SOCIAL SECURITY #______________________ EDU. BACKGROUND (optional) _________________________

PLACE OF EMPLOYMENT____MARITAL STATUS ____________

EMERGENCY INFORMATION

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY_______________________________________

ADDRESS____RELATIONSHIP TO PATIENT______________

HOME PHONE__________________CELL PHONE________________BUSINESS PHONE________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY____

INSURED NAME_______________________________DATE OF BIRTH___________SS#_______________

INSURED ADDRESS________________________________CITY____________STATE_________ZIP______

INSURED PLACE OF EMPLOYMENT____

ID #______________________GROUP #_________________RELATIONSHIP TO PATIENT_____________

SECONDARY INSURANCE COMPANY____

INSURED NAME_______________________________DATE OF BIRTH___________SS#_______________

INSURED ADDRESS________________________________CITY____________STATE_________ZIP______

INSURED PLACE OF EMPLOYMENT____

ID#_______________________GROUP#_________________RELATIONSHIP TO PATIENT_____________

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION

I, THE UNDERSIGNED, CERTIFY THAT I (OR MY DEPENDANT) HAVE INSURANCE COVERAGE WITH______________________________. I ASSIGN DIRECTLY TO SUMTER FAMILY MEDICINE ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR THEIR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES THAT ARE NOT PAID BY MY INSURANCE COMPANY. I, HEREBY AUTHORIZE SUMTER FAMILY MEDICINE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.
PATIENT/GUARDIAN/POA

SIGNATURE____DATE__________________________