PATIENT ACCOUNT NUMBER_____

DATE_____

Welcome to the SFM Family

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

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_____