LCR PATIENT INFORMATION

Last Name	First Name		Middle Init
Street Address		**Apt/Lot #**	
City	**State**	**Zip**	**DOB**
Social Security # - -		**Circle One:** Mr. Mrs. Ms. Miss Dr.	
Cell Phone ( ) -		**Phone Number (**) -	
Email Address		**Employment** Full-time Part-time Retired Disabled	
	Sex M F	**Marital Status** S M W D	**Student?** Yes No Full-time Part-time

Referring Physician	**Phone Number**
Primary Care Physician	**Phone Number**
Spouse	**Phone Number**
Emergency Contact	**Phone Number**

Primary Insurance		
Policy Holder Name	**DOB**	**SSN**
Policy Number	**Group #**	**Group Name**
Secondary Insurance		
Policy Holder Name	**DOB**	**SSN**
Policy Number	**Group #**	**Group Name**

Consent for Treatment, Payment, and Acknowledgement of Receipt of Notice of Privacy Practices: I request that payment under the medical insurance program be made payable to Lowcountry Rheumatology for services rendered. I understand that I am financially responsible for all charges incurred at Lowcontry Rheumatology. I authorize disclosure of my personal health information to carry out treatment, payment, or health care procedures. I have received the privacy policy and Notice of Information Practices that provides a more complete description of information uses and disclosures. I agree to pay any and all charges that exceed or not paid/covered by my insurance. In the event my account is turned over to a collection agency, I will be billed the additional collection fees.

Patient / Guardian: _____ Date: _____

Signature