

Carolina Geriatric Specialists, LLC

Geriatric Medicine

244 Church Street

Sumter, SC 29150

803-775-1001



Date: _____

PATIENT INFORMATION:

LEGAL NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ SEX: MALE FEMALE

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

MARITAL STATUS: SINGLE/MARRIED/WIDOWED/DIVORCED/SEPARATED

Preferred Language: English Spanish other _____

Race: African American Native Hawaiian or other Pacific Islander White American Indian or Alaska Native

Ethnicity: Hispanic or Latino Not Hispanic or Latino

EMERGENCY CONTACT:

First contact

NAME _____ RELATIONSHIP _____

Home # _____ Cell # _____ Work # _____

Second contact:

NAME _____ RELATIONSHIP _____

Home # _____ Cell # _____ Work # _____

INSURANCE INFORMATION: (PLEASE PROVIDE A COPY TO RECEPTIONIST FOR OUR RECORDS)

PRIMARY INSURANCE: _____ ID # _____

Policy Holder Name _____ Policy Holder DOB _____

Policy Holder SSN _____

SECONDARY INSURANCE: _____ ID# _____

Policy Holder Name _____ Policy Holder DOB _____

Policy Holder SSN _____

THIRD INSURANCE: _____ ID # _____

Policy Holder Name _____ Policy Holder DOB _____

Policy Holder SSN _____

*** RESPONSIBLE PARTY: (IF OTHER THAN SELF PLEASE PROVIDE FOLLOWING INFORMATION)**

GUARANTOR NAME: _____ RELATIONSHIP _____

ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

HOME # _____ CELL # _____ WORK # _____

ANY/ALL COPAYS ARE DUE AT THE TIME OF SERVICE

I HEREBY AUTHORIZE ANY BENEFITS FOR ALL MEDICAL CLAIMS PERTAINING TO CAROLINA GERATRICS SPECIALIST, LLC TO BE MADE PAYABLE TO CAROLINA GERIATRIC SPECIALISTS, LLC. A PHOTOCOPY OF THIS AGREEMENT IS TO BE CONSIDERED VALID AS AN ORIGINAL. I UNDERSTAND I HAVE THE RIGHT TO REQUEST A RESTRICTION AS TO HOW MY PROTECTED INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS OF THE PRACTICE. CAROLINA GERATRIC SPECIALISTS, LLC IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS THAT I MAY REQUEST. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT CAROLINA GERIATRIC SPECIALISTS, LLC HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT. I ALSO UNDERSTAND I HAVE THE RIGHT TO REVIEW CAROLINA GERIATRIC SPECIALISTS, LLC NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. I UNDERSTAND THAT CAROLINA GERIATRIC SPECIALISTS, LLC HAS THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND I MAY BE CHARGED FOR ANY APPOINTMENT THAT IS NOT CANCELLED BEFORE THE TIME OF THE APPOINTMENT. I HEREBY AUTHORIZE THAT THE ABOVE INFORMATION IS CORRECT.

PATIENT SIGNATURE/RESPONSIBLE PARTY _____

RELATIONSHIP IF NOT SELF _____ DATE _____