



1 Wellness Boulevard, Suite 203 • Irmo, South Carolina 29063
T 803.732.4608 • F 803.732.4692

PATIENT INFORMATION

PLEASE PRINT CLEARLY

DATE _____

Full Name _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Employer/School _____ Occupation _____

Employer Address _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Date of Birth _____ SS# _____

Patient ID/Nickname _____ Marital Status S M D W Driver's License # _____

Husband's Full Name _____ Husband's Employer _____

Employer's Address _____

Work Phone # _____ Husband's SS# _____ Date of Birth _____

Are you allergic to any medication? _____

Nearest Relative Not Living with you _____ Phone # _____

Do you have medical insurance? Y N Referred by _____

*IN THE EVENT OF HOSPITALIZATION OR MAJOR PROCEDURES, WE REQUEST YOUR INSURANCE INFORMATION FOR OUR RECORDS.

PRIMARY INSURANCE TO FILE

Policy # _____ Group # _____

Insured's Name _____ Relationship to Patient _____

Insured's Social Security # _____ or ID # _____

Insurance Co. Name _____ Insurance Co. Phone # _____

Insurance Co. Address _____

SECONDARY INSURANCE TO FILE

Policy # _____ Group # _____

Insured's Name _____ Relationship to Patient _____

Insured's Social Security # _____ or ID # _____

Insurance Co. Name _____ Insurance Co. Phone # _____

Insurance Co. Address _____

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize this authorization allows Kulbersh Women's Center to release any information to any of my insurers or physicians as requested by any such insurer or physician.

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE, GROUP POLICY BENEFITS AND OTHER HEALTH PLANS TO KULBERSH WOMEN'S CENTER. KULBERSH WOMEN'S CENTER DOES NOT EXTEND CREDIT. I HEREBY AGREE TO PAY ALL COSTS AND REASONABLE ATTORNEY FEES IN THE EVENT THIS ACCOUNT IS TURNED OVER TO AN ATTORNEY AT LAW FOR COLLECTION.

I understand that I am financially responsible to Kulbersh Women's Center for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or have an agreeable payment arrangement set up with the business office.

Signed _____ Date _____

_____ Date _____

Responsible Party Signature (if different)