

Date \_\_\_\_\_

Lovelace Family Medicine, P.A.

Chart # \_\_\_\_\_

**PATIENT INFORMATION**

Account # \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

CELL PHONE # \_\_\_\_\_

HOME STREET ADDRESS: \_\_\_\_\_

HOME PH#: \_\_\_\_\_

CITY,STATE,ZIP \_\_\_\_\_

WORK PH#: \_\_\_\_\_

MAILING STREET OR BOX ADDRESS: \_\_\_\_\_

EmailADDRESS \_\_\_\_\_

CITY,STATE,ZIP \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

DOB: \_\_\_\_\_ SEX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SOCIAL SECURITY#: \_\_\_\_\_

\_\_\_\_\_

PREFERRED LANUAGE \_\_\_\_\_

RACE \_\_\_\_\_

CIRCLE PREFERENCE OF COMMUNICATION: PRINTED ELECTRONIC PHONE

SPOUSE'S NAME: \_\_\_\_\_

WORK PH#: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**NAME & PHONE NUMBER OF EMERGENCY CONTACT:**

NAME: \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_

HOME PH#: \_\_\_\_\_ WORK PH#: \_\_\_\_\_ PAGER/CELL PH#: \_\_\_\_\_

**IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT:**

NAME OF RESPONSIBLE PARTY: \_\_\_\_\_

RELATIONSHIP TO THE PATIENT: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PH#: \_\_\_\_\_ EXT: \_\_\_\_\_

**PRIMARY COVERAGE**

**SECONDARY COVERAGE**

INSURANCE CO: \_\_\_\_\_

INSURANCE CO: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

INSURED'S DATE OF BIRTH \_\_\_\_\_

INSURED'S DATE OF BIRTH \_\_\_\_\_

ID/POLICY#: \_\_\_\_\_

ID/POLICY#: \_\_\_\_\_

GROUP#: \_\_\_\_\_

GROUP#: \_\_\_\_\_

INSURED'S SS# \_\_\_\_\_

INSURED'S SS# \_\_\_\_\_

INSURED'S EMPLOYER \_\_\_\_\_

**\*\*\*Please give a copy of your insurance card to the front desk personnel.**

PATIENT/PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**AUTHORIZATION FOR ASSIGNMENT OF MEDICAL BENEFITS AND RELEASE OF INFORMATION**

1. I hereby authorize and direct Lovelace Family Medicine, P.A. to provide such services for me as they deem reasonable and necessary.
2. I hereby authorize my insurance benefits to be paid directly to Lovelace Family Medicine, P.A.
3. I hereby authorize the release of pertinent information necessary to process my claims and copy of this authorization to be used as an original.
4. I understand I am responsible for payment of any services not covered by my insurance company.
5. I understand that all payments, copays, and deductibles are due at the time of service.
6. I understand that if I fail to cancel four appointments in one year without notification ahead of time that I may be dismissed from the practice. If I fail to cancel two appointments, I may be charged \$5.00 billed directly to me.
7. I understand there is a \$15.00 charge for returned checks.
8. I understand Lovelace Family Medicine, P.A. files insurance and accepts assignment for Medicaid, Medicare, Blue Cross/Blue Shield, PPC, State Health Plan, Health Care Savings, Health Source and Carolina Care Plan on my behalf.

**NOTICE CONCERNING COMPLAINTS:**

Complaints about physicians as well as other licensees and registrants of the South Carolina State Board of Medical Examiners, including physician’s assistants, may be reported for investigation at the following address:

Carolina Medical Review  
250 Berryhill Road, Suite 101  
Columbia, SC 29210

Assistance in filling a complaint is available by calling 1-800-583-2236

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PATIENT NAME (PRINT): \_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT/PARENT SIGNATURE: \_\_\_\_\_