Spartanburg Dermatology & Skin Surgery Clinic, P.C.

2020 North Church Place • Spartanburg, S.C. 29303

INFORMATION SHEET

❑ NEW ❑ UPDATE

DATE:_____
PHYSICIAN:_____
CHART #:_____
*** FOR OFFICE USE ONLY ***

HOW DID YOU LEARN ABOUT US?_____
REFERRING DOCTOR:_____
FAMILY DOCTOR:_____

PATIENT INFORMATION

NAME (FIRST, MI, LAST)_____
BILLING ADDRESS_____
CITY, STATE, ZIP_____
HOME PHONE #_____ CELL PHONE#_____ DATE OF BIRTH_____ SEX_____
MARITAL STATUS_____ SOCIAL SECURITY #_____
EMAIL_____
EMPLOYER_____ PHONE #_____
EMPLOYER ADDRESS_____
CITY, STATE ZIP_____
STUDENT: ❑ YES ❑ NO IF STUDENT: ❑ FULL-TIME ❑ PART-TIME
RACE: (check one) ❑ White ❑ Black or African American ❑ Asian ❑ American Indian/Alaskan Native ❑ Native Hawaiian/Pacific Islander ❑Other ❑ Decline
LANGUAGE: (check one) ❑ English ❑ Spanish ❑ Chinese ❑ French ❑ German ❑Other ❑ Decline
ETHNICITY: (check one) ❑ Not Hispanic/Not Latino ❑ Hispanic/Latino ❑ Decline

RESPONSIBLE PARTY

NAME (FIRST, MI, LAST)_____
ADDRESS_____
CITY, STATE, ZIP_____
PHONE #_____ SOCIAL SECURITY #_____

OTHER INFORMATION

EMERGENCY CONTACT_____
RELATIONSHIP TO PATIENT_____ PHONE #_____

IF PATIENT IS MARRIED, SPOUSE'S NAME_____ WORK #_____
IF PATIENT IS A CHILD, FATHER'S NAME_____ WORK #_____
MOTHER'S NAME_____ WORK #_____

INSURANCE INFORMATION

PRIMARY_____
GROUP #_____ POLICY #_____
POLICY HOLDER_____ SSN:_____ DATE OF BIRTH_____
SEX (M/F)_____ RELATIONSHIP TO PATIENT_____
EMPLOYER_____

SECONDARY
GROUP #_____ POLICY #_____
POLICY HOLDER_____ SSN:_____ DATE OF BIRTH_____
SEX (M/F)_____ RELATIONSHIP TO PATIENT_____
EMPLOYER_____

******* PLEASE READ AND SIGN ON THE OTHER SIDE *******

STATEMENT TO ASSIGN MEDICARE BENEFITS TO PHYSICIAN OR SUPPLIER

Patient's Name: _____

Medicare Number: _____

"I request that payment of authorized Medicare Benefits be made on my behalf to Spartanburg Dermatology and Skin Surgery clinic, P.C. for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Signature of Patient: _____ Date: _____

STATEMENT TO ASSIGN MEDIGAP BENEFITS TO PHYSICIAN OR SUPPLIER
(Medicare Supplemental Insurance)

"I authorize Medicare to file my supplemental (Medigap) insurance. I request that payment be made to Spartanburg Dermatology & Skin Surgery Clinic, P.C. for any services furnished to me by that physician. I authorize the release of any medical information necessary to process this claim."

Signature of Patient: _____ Date: _____

Supplemental Insurance Co.: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that my insurance(s) may not cover the entire cost of all services received in this office, therefore, I recognize that ultimate financial responsibility for my account remains mine. I hereby guarantee payment in full of any and all charges for services rendered not covered by any health benefits plan, including all deductible and coinsurance amounts.

Signature of
Patient/Responsible Party: _____ Date: _____

TELEPHONE MESSAGE RELEASE

The staff and physicians of Spartanburg Dermatology & Skin Surgery Clinic, P.C. have my permission to leave all necessary messages regarding the patient listed above on the voice mail or answering machines located at the telephone numbers listed on the Patient Information Sheet. I also give my permission to leave a message regarding the patient listed above with any adult who answers the phone at any number listed on the Patient Information Sheet.

DATE _____ SIGNED _____
Patients age 16 and over

DATE _____ SIGNED _____
Parent or Legal Guardian
(required for minors through age 17)