9291 Medical Plaza Drive | N. Charleston, SC 29406 | 843-797-3664 | www.lcwomensspecialists.com

PATIENT INFORMATION

Name ____
Last First Middle Init.

Race ________ Marital Status M S D W (circle)

Address ____
Street Apt.

____
City State Zip

Date of Birth ____

Social Security # ____

State Driver's License # ____

Primary Phone ____

Alternate Phone ____

Email ____

Employer Name ____

Address ____
Street of P.O. Box Suite #

____
City State Zip

GUARANTOR/INSURED'S INFORMATION

Insurance Company ______________________________

Name of Insured ______________________________

Insured's DOB ______________ SSN ______________

Policy Number ______________________________

Relationship to Insured ______________________________

Employer Name ______________________________

Employer Phone ______________________________

**NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU FOR AN EMERGENCY

Name ______________________________
Last First Relation

Phone# ______________________________

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. If this account has to be turned over for collection, the undersigned guarantor (parent or guardian if patient is a minor) agrees to pay collection and attorney's fees.

Our office policy is not to release medical records directly to patients. We will gladly forward copies of records to another physician or hospital upon receipt of a written request. If records must be released directly to patients, at least five (5) working days prior notification is required in writing, and the patient will have to pay record release charges when request is made.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Low Country Women's Specialists, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. I certify that the above information is true and correct.

I understand that I am to IMMEDIATELY notify Low Country Women's Specialists if ANY changes occur in my insurance.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT.

____ ______________________________
Signature Witness

Date: ____ Date: ______________________________