LOWCOUNTRY
Women's Specialists
WE TAKE CARE OF YOU FOR LIFE

843-797-3664 | LOWCOUNTRYWOMEN.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:_____