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

PATIENT INFORMATION
(Copy of Driver's License is Required)

Name _____
Last First MI

Race: _____ Marital status: M S D W (circle)

Address _____
_____

Date of Birth _____

Social Security Number _____

State/Driver's License # _____

Primary Phone _____

Cell Phone _____

Email _____

Employer Name _____

GUARANTOR/INSURED'S INFORMATION
(Copy of Primary and Secondary Insur Cards Required)

Insurance Company _____

Insured's Name _____

Insured DOB _____ SSN _____
Policy Number _____

Relationship to Insured _____

Employer Name _____

Secondary Insurance _____

Insured's Name _____

Insured DOB _____ SSN _____

Policy Number _____

EMERGENCY CONTACT _____

Relation (**Nearest relative/friend) _____

Phone # _____

Please answer the following questions:

I want to have access to the patient web portal Y/N

I agree to receive text messages from our portal Y/N

I agree to receive email messages from the portal Y/N

I consent to LCWS leaving detailed voicemails at the number(s) provided. Y/N

Phone # _____

_____ (Initial) I understand that if I decline to receive emails or texts or if my voicemail is full, LCWS will resort to US Postal mail to the address provided and cannot confirm timely receipt.

_____ _____
Patient Date LCWS employee initial