

CAROLINA FAMILY CARE
DURST FAMILY MEDICINE

306 STATION 22 1/2 STREET * SULLIVAN'S ISLAND, SC 29482

PATIENT INFORMATION (Please PRINT)

PATIENT

Last Name _____ First _____ MI _____
Address _____ City _____ ST _____ Zip _____
Home# _____ Work #: _____ Cell #: _____ Pager #: _____
Date of Birth _____ Marital Status: Married Single Widow Divorced Gender: M F
SSN _____ Driver's License No _____ ST _____
Primary Care Doctor: _____
Email Address _____ Referred By _____

Employer/School Name _____
Address _____ City _____ ST _____ Zip _____
Person Responsible for the Bill: Self Spouse Parent Other (FILL-OUT BELOW IF OTHER THAN SELF)
Last Name _____ First _____ MI _____
Address _____ City _____ ST _____ Zip _____
Home #: _____ Work #: _____ Cell #: _____ Gender: M F
SSN: _____ Date of Birth _____

Ins. Company _____
Mail claims to _____ City _____ ST _____ Zip _____
General Phone _____ Claims Phone _____
Group Number _____ Group Name _____
Co-Pay: \$10 \$20 \$ _____ Coverage _____
Policyholder Name _____ Policy No _____
Policyholder DOB _____ Policy holder is self spouse parent

Ins. Company _____
Mail claims to _____ City _____ ST _____ Zip _____
General Phone _____ Claims Phone _____
Group Number _____ Group Name _____
Co-Pay: \$10 \$20 \$ _____ Coverage _____
Policyholder Name _____ Policy No _____
Policyholder DOB _____ Policyholder is self spouse parent

Emergency Contact _____ Phone _____ Relation to Patient: _____
Address _____ City _____ ST _____ Zip _____

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows LMC Physician Practices to release any information to any of my insurers or physicians as requested by any such insurer or physician. I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare, Private Insurance, Group Policy Benefits and Other Health Plans to LMC Physician Practices do not extend credit. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection. I understand that I am financially responsible to LMC Physician Practices for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or have an agreeable payment arrangement set with the business office.

Signed: _____ Date: _____
Signed: _____ Date: _____

As a courtesy to our patients we will file your insurance claims. Please help us by providing accurate information.