

Kiawah Island Family Medicine

Patient Information Form

Personal Information

Full Name: _____
Last First M.I.

Name of Parent (if patient is a child): _____

Primary Mailing Address: _____

Street Address

City State ZIP Code

Secondary Mailing Address: _____

Street Address

City State ZIP Code

Home Phone: () Alternate Phone: ()

Social Security Number _____

Date of Birth: _____ Marital Status: _____

Primary Insurance: _____

Policy Holder's Name: _____ Policy Holder's Relation to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

**** Please provide receptionist with insurance card for photocopying.**

Emergency Contact Information

Full Name: _____
Last First M.I.

Primary Phone: () Alternate Phone: ()

Relationship: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance with the insurance carriers listed above and assign directly to Dr. Book all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize use of this signature on all insurance forms.

Responsible Party Signature _____ Date _____