Myrtle Beach Family Medicine, PA ***Date:_____***

PLEASE COMPLETE FORM COMPLETELY & PRINT

Patient Name_____
(Last Name) (Legal First) (MI) (Nickname)

Male / Female Date of Birth_____ SSN#_____

Race	Ethnicity	Language	Notification Methods	Marital Status
_Asia	_ Hispanic/Latino	_ English	(check all that apply)	_ Single
_Black	_ Not Hispanic/Latino	_ French	_ Mail	_ Married
_White	_ Prefer not to answer	_ Spanish	_ Phone	_ Divorced
_Other		_ Other_____	_ Email	_ Never
_Prefer not to answer				_ Other

If patient under age **18** list parent/guardian:_____

Mailing Address:_____Apt#_____

_____
(City) (State) (ZipCode)

Physical Address:_____

_____
(City) (State) (ZipCode)

Home Phone # _____Work Phone #_____

Cell Phone #_____Email_____

If you are a visitor or part-time resident please list your out of town address.

_____
(Street or PO Box) (City) (State) (Zip)

Out of Town Phone # (_____)_____(_____)_____

Responsible Party Information

Relationship to patient_____ SS#_____

Last Name:_____First Name:_____MI _____

Mailing Address_____

Employer_____ Phone#_____

Emergency Contact

Name_____Relationship_____

Home Phone#_____Work#_____Cell#_____

Insurance Information

Please fill out completely.
This page will be given to our Insurance Department to file your claims, claims will not be filed if any of this necessary information is missing.

Primary Insurance

Name of Insurance Company_____

*Name of Insured (Name on Card)_____

(*Tricare-Insured is military personnel)

Insured's SS#_____ Insured's Date of Birth___ _____

Insured's Place of Employment_____

Insurance ID Number On Card #_____

Relationship to Insured _____ Group #_____

Secondary or Supplemental Insurance

Name of Insurance Company_____

Name of Insured (Name on Card)_____

Insured's SS#_____ Insured's Date of Birth_____

Insured's Place of Employment_____

Insurance ID Number On Card #_____

Relationship to Insured _____ Group #_____

DRIVER'S LICENSE - STATE_____ #_____

****Please have photo ID and all insurance cards available so we can make copies***.

**Please remember that your insurance contract is between you and your insurance company and you are responsible for making sure all payments are made for services rendered.

Thank you,
MBFM

_____ _____

Signature **Date**