PATIENT INFORMATION SHEET

WELCOME TO OUR PRACTICE

Please complete this form and bring it with you to your scheduled appointment.

If you are taking any medication please bring a list of your medications, your insurance card and a photo identification card.
Please arrive 15 minutes prior to your appointment.

PATIENT INFORMATION

Title ____Last Name _____First Name _____ Middle Initial _____

Street Address _____ Apartment Number _____

Mailing Address _____
(if different from street address)

Zip Code _____ City_____ State ___ Home Phone _____ Cell Phone _____

Email Address: _____

Social Security Number _____Birthday _____ Sex _____ Race _____

Marital Status []Single []Married []Divorced []Widowed []Separated Primary Language _____ Student [] Full-time [] Part-time

Employment [] Full-time [] Part-time [] Unemployed [] Retired Relationship to Insured [] Self [] Spouse [] Child [] Other

Employer/School Name _____

Street Address _____ Apartment Number _____

Zip Code _____ City_____ State ___ Business Phone _____

INSURED/PARENT/LEGAL GUARDIAN (IF OTHER THAN PATIENT)

Title ____Last Name _____First Name _____ Middle Initial _____

Street Address _____ Apartment Number _____

Mailing Address _____
(if different from street address)

Zip Code _____ City_____ State ___ Home Phone _____

Social Security Number _____Birthday _____ Sex _____ Race _____

Marital Status []Single []Married []Divorced []Widowed []Separated Student [] Full-time [] Part-time

Employment [] Full-time [] Part-time [] Unemployed [] Retired Relationship to Insured [] Self [] Spouse [] Child [] Other

Employer/School Name _____

Street Address _____ Apartment Number _____

Zip Code _____ City_____ State ___ Business Phone _____

[] Associates in Surgery, PA
2361 Cypress Circle
Conway, SC 29526
Across from the Emergency Room
side of Conway Medical Center

[] Associates in Surgery, PA
Waccamaw Medical Park South
4367 Riverwood Drive Suite 210A
Murrells Inlet, SC 29576
Across from the main entrance of
Waccamaw Community Hospital

843-347-7291

FORMS MUST BE COMPLETED PRIOR TO APPOINTMENT OR RESCHEDULING MAY BE NECESSARY

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ consent to treatment by the physicians of Associates In Surgery, PA.
Please enter your name on this line

I understand that no guarantee will be made to the outcome of my care or treatment. I understand I may be prescribed medication during the course of my treatment that may make operating heavy equipment or driving a vehicle dangerous. I understand I am taking full responsibility for my own actions while I am under the influence of these medications. _____
Please Initial

I understand that as part of my health care, Associates in Surgery, PA originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity to include my insurance company. I understand I am personally responsible for all co-payment, co-insurance and deductibles due. I understand that if my account is delinquent all payments received may be applied to any past due amount I may owe Associates In Surgery, PA. Should collections actions be required to collect the balance on my account I assume full responsibility for all cost incurred. _____
Please Initial

I consent to Associates in Surgery, PA utilizing telephone voice mail and answering machines for the purpose of leaving an appointment reminder or a message to include name and phone number to call.

I fully understand and accept / decline the terms of this consent.

_____ _____
Patient's Signature **Date**

Most medications prescribed by our physicians will be transmitted electronically. Please provide your pharmacy information below:

_____ _____
Pharmacy Name Phone Number

_____
Address City State