

CORE Physicians
(Columbia Regional Medical Center, LLC)

PATIENT NAME AND ADDRESS (Please Print)

Date _____

Primary Physician _____

Physician You are Seeing Today: _____

Social Security #: _____

Phone number: _____ Cell # _____

Email address: _____

Marital S M W D Sep

Birth Date: ___/___/___ Age: _____ Sex: M F

Preferred method of reminders: Mail Phone

Preferred language: _____ Do you have a living will? Yes No (If yes, please give a copy to your physician.)

IMPORTANT: THIS INFORMATION MUST BE COMPLETED

Nearest Relative or Friend not living at the same address (List two people we can notify in case of emergency):

Name: _____ Phone # _____ Relationship: _____

Name: _____ Phone# _____ Relationship: _____

Referred by (Circle) Relative Friend Yellow Pages Newspaper Office Sign CORE Employee Web Site

We are required by the Federal Health Care Stimulus Incentive Program to collect information regarding the race and ethnicity of our patients. Please check the appropriate answer below. If you prefer not to answer please check Unreported/Refused.

RACE

Asian _____ Native Hawaiian _____ Other Pacific Islander _____

Black/African American (not Hispanic or Latino) _____

American Indian/Alaska Native _____ White (not Hispanic or Latino) _____

Hispanic or Latino (all races) _____ Unreported/ Refused _____

ETHNICITY

American ___ American Indian ___ Asian Indian ___ Mexican ___ Other _____ Unreported/Report _____

PLEASE COMPLETE BOTH SIDES OF FORM AND SIGN

EMPLOYMENT, INSURANCE & FINANCIAL RESPONSIBILITY

Employment Status: Full Time _____ Part Time _____ Student Part Time _____ Student Full Time _____

Employed By: _____ Occupation: _____

Employer Address: _____ Phone # _____ Ext. _____

Spouse/ Guardian's Name: _____ Employed By: _____

Name of Person Responsible for Bill: _____

Address: _____ Phone # _____

Primary Insurance (Name) _____

Name of Card Holder _____ DOB _____

Secondary Insurance (Name) _____

Name of Card Holder _____ DOB _____

CORE PHYSICIANS FINANCIAL POLICY & BENEFIT ASSIGNMENT

I request that payment of authorized health insurance benefits be made to CORE Physicians (Columbia Regional Medical Center, LLC) on my behalf for any services furnished me. I authorize any medical information about me needed to determine benefits payable be release to my designated insurance company and its agents. I understand that any balance left on my account after insurance makes it determination is my responsibility. I also understand if I do not have insurance coverage I am responsible for the entire bill. In the event any balance due has to be sent to a collection agency for non-payment, the patient or responsible party will pay all cost of collection, court costs, attorney fees and/or any other expense required to collect the balance.

Patient Signature (or parent/responsible party)

Date

**PLEASE BRING INSURANCE CARDS & PHOTO ID
TO FRONT DESK**

PLEASE COMPLETE BOTH SIDES OF FORM AND SIGN.