PATIENT INFORMATION

Thank you for choosing Palmetto Infusion Services as your infusion therapy provider. Please complete this form and bring it with you to your first appointment. **We will also need a copy of your driver's license and insurance cards.**

Patient Name Last, First____

Responsible Party if Minor__________________________**Relation to patient**__________________

Physical Address____________________________________**City**__________**State**_______**Zip**_______

Mailing address if different__________________________**City**__________**State**_______**Zip**_______

Home Phone #_____________________________________**Cell #**____________________________

Email:____ **May we contact you via email?** ☐ **Yes** ☐ **No**

Social Security# (required)_________________**Date of Birth**______________________**Age**_________

Emergency Contact/Relationship:_______________________________**Contact #**_________________

Are you a Full Time Student __________**Name of School**_____________________________________

Employer Name_______________________________________**Phone #**_________________________

Employer Address___________________________________**City**____________**State**_______**Zip**______

Are you currently working?____

Have you applied for Social Security Disability?__________________**If yes, when?**__________________

Was your application **Approved**_______ **Pending**_______ **Denied**___

Have you applied for Medicaid__________**If yes, were you** **Approved**___**Denied**___

Have you applied for Co-Pay or other assistance for your medication? Yes________**No**___________

If assistance program is available, would you be willing to apply? **Yes**________**No**___________

For Appointment reminders: **Choose one: (Will leave message on phones)**

_____ **Call Home** _____**Call cell** _____ **Text** _____**Email**

CONFIDENTIAL

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PALMETTO INFUSION SERVICES

Insurance Information

Primary Insurance Carrier Name___________________________Phone__________________________________

Claims address_____________________________________City___________________State_____Zip________

Insured Person____Insured's Date of Birth________________

Insured's Social Security#____________________Policy#_____________________Group#___________________

Your Relationship to the Insured Person Self_____Spouse____Child___Other_________________________

Insured Persons Employer Name_______________________________________Phone_____________________

Insured Persons Employer Address________________________________City____________State___Zip_____

For those patients who have Medicare: Do you have a Part D plan? ___Yes ___No. If yes, What is the name of the plan?______________________________Contact number for the Plan:_____________________________________

Secondary Insurance Carrier Name____Phone___________________

Claims address____City___________________State____Zip______

Insured Person____Insured's Date of Birth________________

Insured's Social Security#____________________Policy#____________________________Group#____________

Your Relationship to the Insured Person: Self_____Spouse___Child___Other_________________________

Insured Persons Employer Name_______________________________________Phone_____________________

Insured Persons Employer Address_______________________________City____________State____Zip______

Tertiary Insurance Carrier Name_______________________________________Phone_____________________

Claims address______________________________________City___________________State_____Zip________

Insured Person____Insured's Date of Birth__________________

Insured's Social Security#____________________Policy#__________________Group#______________________

Your Relationship to the Insured Person: Self_____Spouse___Child___Other________________________

Insured Persons Employer Name______________________________Phone______________________________

Insured Persons Employer Address________________________________City____________State____Zip____

Do you anticipate any changes with your insurance in the upcoming year? □ Yes □ No

If yes, please explain:____

My signature certifies all information provided is true and accurate to the best of my knowledge. Should any of the above stated information change, I agree to notify Palmetto Infusion Services immediately.

Signature____Date______________________________

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