



Patient Name: Last, First _____

Responsible Party, if Minor _____ Relation to patient _____

Address _____ City _____ State _____ Zip _____

Mailing address if different _____ City _____ State _____ Zip _____

Home phone _____ Cell _____ Work _____

Email: _____ May we contact you via email? Y ___ N ___

Social Security #(required) _____ DOB _____ Age _____

Emergency Contact/Relation: _____ Phone _____

HIPAA Contacts/Relation: (1) _____ (2) _____

(3) _____ (4) _____

Are you a FT student: Y ___ N ___ Name of school _____

Employer Name _____ Phone _____

Employer address _____ City _____ State _____ Zip _____

Are you currently working? _____

Have you applied for Social Security Disability? Y ___ N ___ If yes, when? _____

Was your application Approved ___ Denied ___ Pending ___

Have you applied for Medicaid? Y ___ N ___ If yes, were you Approved ___ Denied ___

Have you applied for copay assistance or other assistance for your medication? Y ___ N ___

If an assistance program is available, would you be willing to apply? Y ___ N ___

ARE THERE ANY CHANGES WITH YOUR REFERRING PHYSICIAN?

Y ___ N ___

If yes, please provide information _____

PALMETTO INFUSION SERVICES

Primary Insurance Carrier Name _____ Phone _____

Claims address _____ City _____ State _____ Zip _____

Name of Insured _____ Insured's DOB _____

Insured's Social Security # _____ Policy# _____ Grp# _____

Relationship to the Insured Person: Self ___ Spouse ___ Child ___ Other _____

Insured Person's Employer Name _____ Phone _____

Insured Person's Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance Carrier Name _____ Phone _____

Claims address _____ City _____ State _____ Zip _____

Name of Insured _____ Insured's DOB _____

Insured's Social Security # _____ Policy# _____ Grp# _____

Relationship to the Insured Person: Self ___ Spouse ___ Child ___ Other _____

Insured Person's Employer Name _____ Phone _____

Insured Person's Employer Address _____ City _____ State _____ Zip _____

Other Insurance Carrier Name _____ Phone _____

Claims address _____ City _____ State _____ Zip _____

Name of Insured _____ Insured's DOB _____

Insured's Social Security # _____ Policy# _____ Grp# _____

Relationship to the Insured Person: Self ___ Spouse ___ Child ___ Other _____

Insured Person's Employer Name _____ Phone _____

DO YOU ANTICIPATE ANY CHANGES WITH YOUR INSURANCE IN THE UPCOMING YEAR? Y ___ N ___

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 _____