Palmetto Infusion Services

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_____

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_____