Adult Medicine Specialists, PA

764 Saco Lowell Road, Easley, SC 29640
Phone: 864-855-5525 Fax: 864-855-5440

New Patient Screening Form

Current Physician:_____

Please Print

Patient Full Name:_____
Last First Middle

Mailing Address:_____

_____ _____ Phone:_____
City State Zip

Email Address: _____ Ethnicity: _____

Age:_____ Date of Birth:_____ Sex:_____ Social Security #:_____
Is patient a student?_____ Marital Status:_____ Driver's License:_____
Patient Employer:_____ Occupation:_____
Employer Address:_____ Phone:_____
Name of Spouse:_____ Phone:_____
Spouse Social Security #:_____ Date of Birth:_____
Spouse Employer:_____ Occupation:_____
Employer Address:_____ Phone:_____
Emergency Contact Name (Outside of home):_____
Emergency Contact Phone: Home_____ Cell_____

If Patient is a minor/dependent upon a parent/guardian:

Mother's Name:_____ Employer:_____ Phone:_____
Father's Name:_____ Employer :_____Phone:_____
Legally Responsible Person's Name: _____Relationship to patient:_____
Legally Responsible Person's Address:_____
Legally Responsible Person's Social Security:_____
Legally Responsible Person's Phone #:_____

Insurance:

Primary Insurance:_____ Secondary Insurance:_____
Subscriber Name:_____ Subscriber Name:_____
Subscriber's Date of Birth: _____Subscriber's SSN: _____
ID #:_____ ID#:_____
Group #:_____ Group #:_____

Medication List (Please list ALL medications that patient takes.) List known medication allergies.

_____ _____
_____ _____
_____ _____
_____ _____

Treatment Authorization: I hereby authorize Adult Medicine Specialists of Easley, P.A. to examine and treat the patient named above. Insurance Authorization and Assignment: I hereby give permission for Adult Medicine Specialists of Easley, P.A. to release any and all information concerning patient's condition and/or treatment to insurance carrier either by mail or fax. I also authorize payment to be made directly to Adult Medicine Specialists of Easley, P.A. for services rendered to the patient named above. I also understand I am responsible for the charges not covered by my insurance company or by Medicare.

Signature:_____ Date:_____

Insurance:

Primary Insurance:_____ Secondary Insurance:_____

Subscriber Name:_____ Subscriber Name:_____

Subscriber's Date of Birth: _____Subsriber's SSN: _____

ID #:_____ ID#:_____

Group #:_____ Group #:_____

Medication List (Please list ALL medications that patient takes.)

_____ _____

_____ _____

_____ _____

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Signature:_____ Date:_____