Adult Medicine Specialists, PA

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

New Patient Screening Form (Please Print)

Current Physician: _____

Patient Full Name: _____
Last First Middle

Mailing Address: _____ Phone: _____
City State Zip Code

Email Address: _____ Race: _____ Ethnicity: _____

Age: _____Date of Birth_____ Social Security Number: _____

Birth Sex: _____ Identifies As: _____

Is patient a student? _____Marital Status: _____ Driver's License: _____

Patient Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

Spouse's Name: _____Employer: _____Occupation: _____

Spouse Social Security: _____ Date of Birth: _____

Spouse Employer Address: _____ Phone: _____

Emergency Contact Name: _____

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 Number: _____

Insurance:

Primary Insurance: _____ Secondary Insurance: _____

Subscriber's Name: _____ Subscriber's Name: _____

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

ID #: _____ ID #: _____

Group #: _____ Group #: _____

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

_____ _____

_____ _____

_____ _____

_____ _____

Treatment Authorizations: 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**: _____