Carolina Women's Care

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ________________________(First)________________(MI)__________Previous Name________________

Address ____

City, State _________________________________ Zip ___________________Email address: _________________________

Home Phone _____________________ Cell Phone _______________________ Work Phone _______________ Ext ________

Primary Care Provider (PCP) _________________________________ Referring Provider _____________________________

Date of birth: MM_________/DD__________/YYYY______________ Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other____________

Ethnicity: ☐ Hispanic or Latino ☐Not Hispanic or Latino ☐ Declined

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _________-_________-_____________ Employer Name _________________________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐Active Military

Student Status: ☐Full Time Student ☐Part Time Student ☐Not a Student

Emergency Contact Last Name ____ First Name ___________________________

Address ____

City, State _________________________________ Zip ___________________Email address: _________________________

Home Phone _____________________ Cell Phone _______________________ Work Phone _______________ Ext ________

How did you hear about us? ____

RESPONSIBLE PARTY INFORMATION (Information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Click here if information is same as patient ☐**

Last Name __________________________________ First Name __________________________________ Middle___________

Social Security Number _________-_________-_____________ Date of Birth MM_________/DD__________/YYYY______________

Sex ☐ Female ☐ Male ☐ Transgender Telephone ____

Email address _________________________________

Mailing Address: ____City/State/Zip_____________________________

Employer: ____ Employer Phone Number _________________________

PRIMARY INSURANCE INFORMATION (Provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ____ (______)______________

Name of Insured: ____ Patient Relationship to Insured___________________

Subscriber ID #: ______________________________________ Group ID # ___________________Co-Pay $________________

Effective Date ___________________ Termination Date ______________Date of Birth: ________________________________

SECONDARY INSURANCE INFORMATION (Provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ____ (______)______________

Name of Insured: ____ Patient Relationship to Insured___________________

Subscriber ID #: ______________________________________ Group ID # ___________________Co-Pay $________________

Effective Date ___________________ Termination Date ______________Date of Birth: ________________________________

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature ____***Today's Date***________________