

Date \_\_\_\_\_

Carolina Diabetes and Endocrine Clinics

**PATIENT INFORMATION**

Legal Name: \_\_\_\_\_

First

MI

Last

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Sex: M F Circle Marital Status: Single Married Widowed Divorced

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Referring Dr: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Dr.: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City State Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

Allergies: \_\_\_\_\_

Email Address: \_\_\_\_\_

**SPOUSE**

**OTHER EMERGENCY CONTACT**

Relation: \_\_\_\_\_

Name \_\_\_\_\_ | \_\_\_\_\_

Email \_\_\_\_\_ | \_\_\_\_\_

Work Phone \_\_\_\_\_ | \_\_\_\_\_

Cell Phone \_\_\_\_\_ | \_\_\_\_\_

Home Phone \_\_\_\_\_ | \_\_\_\_\_

Address \_\_\_\_\_ | \_\_\_\_\_

City State Zip \_\_\_\_\_ | \_\_\_\_\_

Soc Sec # \_\_\_\_\_ | \_\_\_\_\_

Date of Birth \_\_\_\_\_ | \_\_\_\_\_

Employer \_\_\_\_\_ | \_\_\_\_\_

Work Phone \_\_\_\_\_ | \_\_\_\_\_

Date \_\_\_\_\_

\*\*\* Please complete reverse side \*\*\*

## **INSURANCE INFORMATION**

Please give your insurance cards to the receptionist to copy for your chart and complete the following information:

### **PRIMARY INSURANCE INFORMATION**

Name of Insurance Company \_\_\_\_\_

Address to mail claims \_\_\_\_\_

City State Zip \_\_\_\_\_

Customer Service Phone \_\_\_\_\_

Preauthorization Phone \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Relationship of Policy Holder to Patient \_\_\_\_\_

Policy Holder Employer Name \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Insurance Effective Date \_\_\_\_\_

### **SECONDARY INSURANCE INFORMATION**

Name of Insurance Company \_\_\_\_\_

Address to mail claims \_\_\_\_\_

City State Zip \_\_\_\_\_

Customer Service Phone \_\_\_\_\_

Preauthorization Phone \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Relationship of Policy Holder to Patient \_\_\_\_\_

Policy Holder Employer Name \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Insurance Effective Date \_\_\_\_\_