DEPARTMENT OF INTERNAL MEDICINE

803.540.1000

PATIENT PRE-REGISTRATION INFORMATION **PATIENT NUMBER:**

FOR DOCTOR: _____ **DATE OF REFERRAL:** _____

REFERRING MD: _____ **REF DR NPI /UPIN #S:** _____/_____

REF MD ADDRESS: _____
Street City State Zip

REF CONTACT NAME: _____ **REF. PHYSICIAN PHONE #: (____)** _____ **EXT:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE#: (____)** _____ **EXT:** _____

REF MD SIGNATURE IF CONSULT OR FAX CONSULT LETTER OR SIGNED ORDER OR PHYSICIAN NOTE WITH REFERRAL:

REF MD SIGN HERE: _____

PATIENT NAME: _____
Last First Middle

ADDRESS: _____
City State Zip

PHONE NUMBER: (____) _____ **WORK NUMBER: (____)** _____ **DOB:** _____

SSN: _____ **GENDER:** _____ **MARITAL STATUS:** _____

REASON FOR REF/VISIT: _____

EMERGENCYCONTACT NAME: _____
Last First Middle

RELATIONSHIP: _____ **PHONE# :(____)** _____

INSURANCE: SEND COPY OF INSURANCE CARD(S) FRONT AND BACK WITH REFERRAL: SELF PAY _____ **INDIGENT** _____

PRIMARY COMPANY NAME: _____ **POLICY ID #:** _____
POLICY GROUP #: _____

MAILING ADDRESS: _____

PHONE #: (____) _____ **SUBSCRIBER NAME:** _____

SUBSCRIBER DOB: _____ **RELATIONSHIP TO PATIENT** _____ **EFFECTIVE DATE:** _____

SECONDARY COMPANY NAME: _____ **POLICY ID #:** _____
POLICY GROUP #: _____

MAILING ADDRESS: _____

PHONE# (____) _____ **SUBSCRIBER NAME:** _____

SUBSCRIBER DOB: _____ **RELATIONSHIP TO PATIENT** _____ **EFFECTIVE DATE:** _____

EMPLOYER: _____ **PHONE #:** _____

EMPLOYER ADDRESS: _____

OFFICE USE ONLY

APPOINTMENT DATE AND TIME: _____ **REF MD NOTIFIED DATE:** _____

INFO TAKEN/ENTERED INTO TIGER BY: _____ **DATE NP PACKET MAILED:** _____

PATIENT FINANCIALS

EXPECTED CO- PAY_____
DEDUCTIBLE:_____**MET**
$_____ **NOT MET**
ATTACHED DOCUMENTATION (INITIAL):_____