Carolina Center *for* Restorative Medicine
Restoring Hope and Health with Heart

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Patient Information Sheet

Date: _____ Medical Record Number: _____

First Name: _____ Middle/Maiden:_____ Last: _____

Proof of Identification: Driver's License (State and Number) _____

Or Alternate Method of Identification: _____

Name you wish to be called in the office:_____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State:_____ Zip:_____

Home Telephone: _____Work Telephone:_____

Cell Phone: _____ Email Address: _____

What is your preferred method of communication? _____

Home Phone – May we leave a message? ◯ Yes ◯ No
Work Phone – May we leave a message? ◯ Yes ◯ No
Cell Phone – May we leave a voice mail message? ◯ Yes ◯ No
May we leave a text message? ◯ Yes ◯ No
Secure Email through the Patient Portal? ◯ Yes ◯ No

Any special concerns (e.g.. English is your second language, hearing impaired, limited mobility, visually impaired)? _____

_____

Emergency Contact Information

Primary Contact Name: _____ Relationship to you: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ Email Address: _____

Secondary Contact Name: _____ Relationship to you: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ Email Address: _____

Employment Information

Occupation: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer Telephone: _____

Primary Care Physician

Physician Name (First and last names): _____

Practice Name: _____

City in which your primary care physician is located: _____

Did your primary care physician give you a referral for this visit? ◯ Yes ◯ No

Pharmacy Information

Pharmacy Name/Location: _____

Pharmacy Telephone: _____ Pharmacy FAX: _____

Insurance Information

We do not participate in government or private insurance plans. If you have insurance coverage and would like our assistance in filing a claim, please bring your insurance card and photo identification to every office visit.

Primary Insurance Carrier: _____

Policy Number:_____ Effective Date:_____

Cardholder Name:_____ Cardholder Date of Birth: _____

Relationship of Cardholder to You: _____ Insurance Phone number: _____

Seconday Insurance Carrier: _____

Policy Number:_____ Effective Date:_____

Cardholder Name:_____ Cardholder Date of Birth: _____

Relationship of Cardholder to You: _____ Insurance Phone number: _____

Patient Signature: _____ Date: _____

Guardian Signature:_____ Date: _____

Thanks! We're glad you came to our practice.

How did you hear about our practice? We appreciate your business and would like to say thanks!

◯ Physician (Provide Name): _____

◯ Friends/Family (Provide Name)_____

◯ Radio ◯ Our website ◯ Insurance carrier website