Patient Information Form

Please fill out this form completely for the best healthcare service.

Patient Name:	Home Phone:
Date of Birth:	Mobile Phone:
Social Security Number:	E-mail Address:
Address:	Employer:
	Work Phone:
Please complete this section if you are covered under the policy of a spouse, partner, parent, or legal guardian	
Name of Subscriber:	Home Phone:
Date of Birth:	Mobile Phone:
Social Security Number:	E-mail Address:
Address:	Employer:
	Work Phone:
Nearest relative or friend to contact in case of emergency:	
Name:	Phone Number:
Relationship:	Alternate Number:
Who may we thank for referring you to us?	Local Pharmacy/Address

I consent to medical care and treatment by the practitioners of Piedmont Healthcare for myself or the above named individual for whom I am legally responsible. I authorized the release of all medical records to other healthcare professionals as required for treatment and to my health insurance company, if applicable. I understand, depending on the tests ordered by my physician that I may receive a separate statement for laboratory, pathology or radiology services.

I acknowledge financial responsibility for services rendered by Piedmont Healthcare. I authorize Piedmont Healthcare to file my insurance and for the insurance payment to be made directly to them. If insured, I understand the co-pay, deductible and/or co-insurance are due at the time or service.
If un-insured, I understand full payment is due at the time of service.

Patient Signature:_____ **Date:**_____