(For Office Use Only)

PHYSICIAN _____ **CHART #** _____

DATE _____ **EMPLOYEE'S INITIALS** _____

Two Richland Medical Park, Suite 306
Columbia, South Carolina 29203-7868

UNIVERSITY SPECIALTY CLINICS®
SURGERY

Telephone: (803) 545-5800

PATIENT INFORMATION

PATIENT'S NAME (LAST) (FIRST) (MIDDLE) **DATE OF BIRTH** MO. DAY YR.

PHYSICAL ADDRESS (NUMBER) (STREET) (CITY) (STATE) (ZIP CODE)

MAILING ADDRESS **MOBILE TELEPHONE**

PATIENT'S SOCIAL SECURITY NUMBER **PATIENT'S SEX** **PATIENT'S MARITAL STATUS** **HOME TELEPHONE**

PATIENT'S OCCUPATION **PATIENT'S EMPLOYER** **HOW LONG EMPLOYED?** **WORK TELEPHONE**

EMPLOYER'S ADDRESS (NUMBER) (STREET) (CITY) (STATE) (ZIP CODE)

PARENT'S OR SPOUSE'S NAME **PARENT'S OR SPOUSE'S SOCIAL SECURITY NUMBER**

PARENT'S OR SPOUSE'S EMPLOYER **ADDRESS** (CITY) (STATE) (ZIP CODE) **WORK TELEPHONE**

FAMILY PHYSICIAN **ADDRESS** (CITY) (STATE) (ZIP CODE) **OFFICE TELEPHONE**

WHO REFERRED YOU TO OUR OFFICE? **ADDRESS** (CITY) (STATE) (ZIP CODE)

EMERGENCY CONTACT PERSON ADDRESS AND PHONE NUMBER OF THE CLOSEST RELATIVE NOT LIVING WITH THE PATIENT:

–ALL OFFICE EXAMINATION FEES ARE DUE FOR PAYMENT ON DATE OF TREATMENT–

INSURANCE INFORMATION–INCLUDE MEDICARE OR MEDICAID

IS THIS A WORKMAN'S COMP CLAIM? _____ **ARE YOU COVERED BY CHAMPUS?** _____

#1 NAME OF INSURANCE CO: **GROUP #:** **or PRIVATE #**

NAME OF INSURED **DATE OF BIRTH** / / **RELATION TO PATIENT** **CERTIFICATE / SOCIAL SECURITY NUMBER**

IF GROUP, EMPLOYER'S NAME **GROUP OR PRIVATE POLICY NUMBER**

ADDRESS TO MAIL INSURANCE CLAIMS

INSURANCE PRECERTIFICATION REQUIRED? _____ **PRECERTIFICATION PHONE #** _____

#2 NAME OF INSURANCE CO: **GROUP #:** **or PRIVATE #**

NAME OF INSURED **DATE OF BIRTH** / / **RELATION TO PATIENT** **CERTIFICATE / SOCIAL SECURITY NUMBER**

IF GROUP, EMPLOYER'S NAME **GROUP OR PRIVATE POLICY NUMBER**

ADDRESS TO MAIL INSURANCE CLAIMS

INSURANCE PRECERTIFICATION REQUIRED? _____ **PRECERTIFICATION PHONE #** _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN/SUPPLIER TO RELEASE INFORMATION: I request that payment of authorized Medicare/Third Party Payer benefits be paid on my behalf to University Specialty Clinics® Surgery for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents and/or Third Party Payers any information needed to determine benefits and/or to other providers for further treatment.

SIGNED _____
SIGNED / INSURED OR AUTHORIZED PERSON

RELATI _____ _____
RELATIONSHIP TO PATIENT **DATE**

(PLEASE READ OUR FINANCIAL AND INSURANCE POLICY ON REVERSE SIDE OF FORM)