PALMETTO FAMILY MEDICINE AND SENIOR CARE

NEW PATIENT APPLICATION

420 WEST CAROLINA AVENUE
HARTSVILLE, SC 29550
843-917-4977

DATE: ______/______/______

PATIENT DEMOGRAPHICS

NAME:____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY # _____-_____-_____

❏ MALE
❏ FEMALE

ADDRESS: ____

CITY: ________________________ STATE: ________________ ZIP CODE: ________________

PRIMARY PHONE: ________________ ▢ HOME ▢ MOBILE ▢ WORK ▢ SPOUSE ▢ CAREGIVER

SECONDARY PHONE:______________ ▢ HOME ▢ MOBILE ▢ WORK ▢ SPOUSE ▢ CAREGIVER

EMAIL ADDRESS: ____

PRIMARY INSURANCE	SECONDARY INSURANCE
______________________________	______________________________

LIST ANY CURRENT MEDICAL PROBLEMS OR CHRONIC ILLNESSES

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LIST ANY PHYSICIANS AND/OR PRACTITIONERS YOU CURRENTLY SEE

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LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, INCLUDING OVER-THE-COUNTER

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I AM APPLYING TO BECOME A PATIENT OF (CIRCLE ONE):

DR. WILLIAM LONG OR DR. JOHN ROPP

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FOR OFFICE USE:

________ **APPROVED** **DR. SIGNATURE** ______________________________ **DATE:** ____________

________ **DENIED** **DR. SIGNATURE** ______________________________ **DATE:** ____________

NOTES (IF APPLICABLE): ____

________ **ACCOUNT CREATED** **ACCT. NUMBER** _____________

________**PATIENT CALLED** **APPT. DATE:** ________________

DATE COMPLETED: ___________________ **EMPLOYEE INITIALS:** _________________