Scheduling / 704-671-5969 Fax / 704-671-7755

SPECIALISTS OF THE CAROLINAS

620 Summit Crossing Place, Gastonia
209 Park Street, Suite 300, Belmont

Patient Registration

M R N:_____

Last Name / First/ MI: _____ / _____ / _____

Date of Birth: _____Social Security # _____ Gender: M / F

Street Address / City / State / Zip _____ / _____/_____/_____

Home Phone / Other Phone _____ / _____ Marital Status: _____

Emergency Contact:_____Phone:_____

Employment: □ Full time □ Part time □ Retired □ None

Employer: _____

Employer Address / Phone: _____/_____

Student: □ Full time □ Part time / Name of School: _____ _____

Referring Physician:_____ Primary Care Physician: _____

Reason for today's visit: _____

Insurance Information

Primary Insurance: _____

Policy #:_____Group #:_____

Name of Policy Holder _____

Social Security #:_____

Address / City / State / Zip _____ / _____ /_____ / _____

Home Phone / Other Phone: _____/_____

Secondary Insurance: _____

Policy #:_____Group #:_____

Name of Policy Holder _____

Social Security #:_____

Address / City / State / Zip _____ / _____ /_____ / _____

Home Phone / Other Phone: _____/_____

Estimated Payment to Collect at Time of Service: $_____

Patient Signature: _____Date:_____