EFFINGHAM
FAMILY MEDICINE℠
YOU ALWAYS MATTER
A Department of Effingham Health System

**Patient Information**

Mr. /Mrs. /Ms.
Last_____First_____ MI_____

Address_____City_____State_____Zip Code_____

Mailing address_____ City_____State_____Zip Code_____

Phone Home_____ Cell_____

Work_____ Ext_____

Date of Birth_____ Male or Female Single/Married/Widowed/Divorced

Social Security No. _____ Employed Y/N Employer _____Full/Part/Retired

Student? Y/N Full Time/Part Time E-mail_____
(Over 18yrs of age only)

**Emergency Contact**

Last _____ First _____

Relationship_____

Address_____ City _____State_____ Zip Code _____Date of Birth_____

Phone Home_____ Cell_____

Work_____ Ext_____

**Guarantor *** (Financially responsible person who is signing the attached forms)

Last _____ First _____ MI_____ M/F

Relation_____

Phone No._____Date of Birth_____ Social Security No. _____

Address_____ City_____ State_____ Zip Code _____

Employer_____ Full /Part Phone_____

Address_____City_____ State _____ Zip Code_____

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**Insurance Information**

Medicare No._____ Part A/A&B /B Medicaid No._____

Wellcare No._____ Amerigroup No._____PeachState No._____

Primary_____ ID No._____ Group No._____

Policy holder_____ Date of Birth_____ Social Security No._____

Address_____City_____State_____

Phone_____

Secondary _____ ID No._____ Group No._____

Policy holder_____ Date of Birth_____ Social Security No._____

Address_____City_____State_____

Phone_____

**Self Pay** Yes or No if yes, please select one of the following

____ Pay balance in full at the time of service ***or*** ____ Make a payment arrangement prior to being seen

**Additional Info**

Race Black/African American Hispanic White
Other_____

Ethnicity Hispanic or Non-Hispanic

Pharmacy Used_____ Location_____ Phone_____

Have you ever received care in any of our offices in the past? If so, which one?
_____

How long ago? _____ under what name did you receive care? _____

**Accident Information**

Is this illness due to an accident? Yes or No

If yes, work or auto accident_____ date of accident_____

Place of
accident_____

If work accident,
Employer_____

Contact person_____ Phone _____

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## MEDICARE INFORMATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to EFFINGHAM HEALTH SYSTEM for any services furnished by me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related Service.

I understand my signature request that payment be made and authorize release of medical information necessary to pay the claim. If item 9 of HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE _____

DATE_____

Please take a brief moment to tell us how you heard about Effingham Family Medicine. Circle all those that apply.

**Advertising**

| | | |
|---|---|---|
| Effingham Herald | Savannah Now (Effingham Now) | Effingham Living Magazine |
| Radio/TV | Billboard | Other_____ |

**Direct Mail**

| | | |
|---|---|---|
| Postcard | Newsletter | Letter |

**Referred**

| | | |
|---|---|---|
| Friend/Family Member | Physician | Emergency Department |