# Sea Pines Circle Immediate Care

2 Greenwood Drive Suite C
Hilton Head Island, SC 29928
Phone: 843.341.2700 Fax: 843.341.2702

**Patient Registration Form (Please Print)**

First Name: _____ MI: _____ Last Name: _____

Date of Birth: ____/____/_____ Social Security #: _____-_____-_____ Sex: Male ☐ Female ☐

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home#: (_____) _____-_____ Work #: (_____) _____-_____ Cell #: (_____) _____-_____

Pharmacy Name and Street: _____ the three closest are: ☐Harris Teeter ☐Walgreens ☐CVS

Marital Status (circle one): Single/Married/Widowed/Other Email Address: _____

Primary Care Physician: _____ Phone #: (_____) _____-_____

Emergency Contact Name: _____ Relationship: _____

Home Number: (_____) _____-_____ Cell Number:( _____) _____-_____

Is the Patient covered under insurance? Yes☐ No ☐

Responsible Party: _____ Relationship to Patient: _____

**Primary Insurance:**
Insurance Plan Name: _____
ID #: _____
Group #: _____
Copay: _____

**Secondary Insurance:**
Insurance Plan Name: _____
ID #: _____
Group #: _____
Copay: _____

**Is patient the policy holder?** YES / NO
**If not, please provide the following:**
Spouse/Parent Name: _____
Date of Birth: _____/_____/_____
Social Security #: _____-_____-_____

**Is patient the policy holder?** YES / NO
**If not, please provide the following:**
Spouse/Parent Name: _____
Date of Birth: _____/_____/_____
Social Security #: _____-_____-_____

**I authorize Sea Pines Circle Immediate Care to release any medical information required during examination and treatment and permit payment directly to them any benefits due for services rendered. I recognize and accept responsibility for services rendered regardless of Insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible and non-covered services.**

Signature of Responsible Party: _____
Date: _____/_____/_____

Please continue to the next two pages, "Medical History Form" and "Authorization to Treat"

# Authorization to Treat

I authorize the physician and staff of Sea Pines Circle Immediate Care to treat me or the person for whom I have responsibility. I understand that this consent to treat includes my consent for medical tests, procedures, drugs, and other services and supplies as considered advisable; and may include, but is not necessarily limited to: anesthesia, pathology, radiology, and other imaging and diagnostic services, and other special test and services including tests for communicable diseases and toxins, as ordered by the physician responsible for my care during my visit to Sea Pines Circle Immediate Care. I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of examination, care, or treatment at Sea Pines Circle Immediate Care. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information, and that failure to do so can adversely impact my care.

I have been offered a copy of Sea Pines Circle Immediate Care 's Notice of Privacy Practices to read and/or take home with me. I understand that if I want more information about these privacy practices or have questions or concerns, I may ask the Center's staff or contact Sea Pines Circle Immediate Care as indicated on the notice.

I authorize Sea Pines Circle Immediate Care, or its agents, to release medical or other information to my insurance company, the Center for Medicare Services, or its carriers, as necessary to determine payment for these or related services. I request that payment authorized by my insurance company, the Center for Medicare Services, or its carriers, be made on my behalf to Sea Pines Circle Immediate Care for services provided by said group. I certify that any information I provide related to my eligibility for coverage or payment is accurate and complete. I understand that I am required to notify Sea Pines Circle Immediate Care of any changes in insurance coverage.

I understand that I am financially responsible for payments of services provided during the visit if I do not have insurance coverage or if I have coverage and timely payment is not made. I also understand that if I have a co-payment for this service, it is payable today. I may be charged an additional fee to cover the cost of billing the co-payment, if not paid today. I understand that I am responsible for paying the amount of any discount imposed if my insurance provider or third-party payer imposed discount which are not authorized by a signed agreement between that payer and Sea Pines Circle Immediate Care.

Certain lab tests may be sent to an independent lab for processing. I understand that I may receive a separate bill for these services. Sea Pines Circle Immediate Care utilizes PathGroup for all Send Out labs.

Some insurance companies require preauthorization for certain services, If I am required to obtain an authorization for today's visit and have not done so, I agree to assume all financial responsibility. If I receive any additional services from specialists, hospitals or other healthcare providers in connection with or as a result of this visit, those charges may also be my responsibility, unless preauthorized as required by my insurance company.

In the event that collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to: court costs, expenses, and attorney fees, to the extent permitted by law. I understand that the foregoing provisions apply equally to any individual for whom I am authorized to consent to treatment, or for whom I qualify as an authorized representative or authorized agent under any laws.

_____ Date: _____

Patient's Signature *If patient is unable to sign, write the patient's name on th signature line above and have guardian or representative sign below.

_____ Date: _____

Parent, Guardian or Representative Signature

_____ Patient's Date of Birth: _____

Print Patient's Name Clearly

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home#: (___) _____-_____ Work #: (_____) _____-_____ Cell #: (_____) _____-_____

# Medical History Form

**Patient Name:**_____ **Date of Birth:** ___/___/___

**Reason for Today's Visit:**_____ **Symptoms Began:**_____

**Gender:** M F **Height:** _____ **Weight:** _____

**Date of Last Menstrual Cycle:** _____ Hysterectomy Menopausal Post-Menopause
Pregnant:____wks

**Employed** Y N Retired Disabled Homemaker Student

**Smoke** Y N FORMER If Yes: Occasionally Daily

*If Patient is a child,* any smokers in the household? Y N

**Drink** Y N If Yes: Socially Daily-(average #per day & type: _____)

**Drugs** (Recreational) Y N If Yes, which drug(s): _____

**Allergies to Medications:** _____ What affect does it have?_____

_____ What Affect does it have? _____

**Chronic Medical Conditions:** _____

_____

**Surgeries:** _____

**List the Family Members affected by any of the following:**

Diabetes _____ Asthma _____ Hypertension _____ Cancer _____ COPD_____

| | | | | |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

**Medication:** **Dosage:** **Taken For:** **Frequency:**

_____

_____

_____

**Tetanus immunization within the last 5 years?** Y N Unsure

*For Office Use Only*

B/P:____ Pulse:____ Resp:____ Temp:____ Pulse Ox:____

Pain Scale: 1 2 3 4 5 6 7 8 9 10