Carolina Arthritis Center

Patient Registration Form

Last Name	First Name	Middle Initial	SSN

Date of Birth	Sex M☐ F☐	Referring Physician	Home Phone ( )

Mailing Address	City	State	Zip
		Email	

Employer Name	Work Phone ( )

Pharmacy Name	Street Address	Phone No.

Contact Phone Number for Appointments and Test Results Between 8:30am and 5:00pm ( )	Cell Phone ( )

Emergency Contact

Name Phone ( )

Insurance Information

Primary	Secondary
Insurance Company Name	Insurance Company Name
Policy Holders Name	Policy Holders Name
Policy Holder Date of Birth	Policy Holder Date of Birth
Policyholder's Social Security Number	Policyholder's Social Security Number
Policy Number	Policy Number
Group Number	Group Number

I hereby authorize my insurance benefits to be paid directly to Carolina Arthritis Center, PA realizing I am responsible for payment of noncovered services.

Patient's Signature ______________________ Date ______________________

I hereby authorize the release of pertinent medical information to insurance carriers and my referring physicians.

Patient's Signature ______________________ Date ______________________