Carolina Arthritis Center

Patient Registration Form

Last Name	First Name	Middle Initial	SSN

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

Mailing Address	City	State	Zip

Email Address	Work Phone
	( )

Pharmacy Name	City	State	Zip

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
Insurance Company Address	Insurance Company Address
Insurance Company Phone	Insurance Company Phone
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_____