Metrolina Medical Associates

2670 Mills Park Drive, Suite 200
Rock Hill, SC 29732-8599
(803) 985-3939

PATIENT INFORMATION

Name (Last, First, MI)	SSN	Birthdate	Sex

Local Address (if PO Box, please include physical address, as well)	City, State, Zip	Home Phone

Cell Phone	Work Phone	Email Address	Martial Status

Student Status □ Full Time □ Part-Time	Smoker?	Veteran?	Emergency Contact Name	Emergency Contact Phone

Race (circle one)	Language (circle one)	Ethnicity (circle one)
□ American Indian/Alaska Native □ Asian BBlack/African American □ Multiracial □ Caucasian/White □ Native Hawaiian/Pacific Islander	□ English □ Spanish □ French □ German □ Other	□ Hispanic or Latino □ Not Hispanic or Latino □ Unknown

Preferred Method of contact (**circle one**):
Home Phone Cell Phone Work Phone Email Other (specify): _____

Employer	Employer Address	Work Phone

RESPONSIBLE PARTY INFORMATION (If different from above. This does not change legal responsibility)

Name (Last, First, MI)	SSN	Birthdate	Sex

Local Address (if PO Box, please include physical address, as well)	City, State, Zip

Home Phone	Cell Phone	Work Phone	Email Address	Relationship to Patient

PRIMARY INSURANCE

Name of Insurance Company	Policy ID #	Group #

Address of Insurance Company	City, State, Zip	Insurance Phone

Effective Date	Copay Amt	Deductible	Name of Insured

Insured Birthdate	Insured SSN	Insured Employer

SECONDARY INSURANCE (If applicable)

Name of Insurance Company	Policy ID #	Group #

Address of Insurance Company	City, State, Zip	Insurance Phone

Effective Date	Copay Amt	Deductible	Name of Insured

Insured Birthdate	Insured SSN	Insured Employer

BY SIGNING THIS, I AGREE THAT THE INFORMATION ABOVE IS TRUE AND ACCURATE.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**