Columbia Heart

Experience. Compassion. Excellence.

Columbia Heart
8 Richland Medical Park Drive
Suite 200 & 300
Columbia, SC 29203
(803) 256-6511

PHYSICIAN: **CHART #:** **MRN:**

PATIENT INFORMATION

NAME (Last, First Middle)				SSN#		BIRTHDATE	SEX
STREET ADDRESS				CITY, STATE, ZIP			
MAILING ADDRESS				CITY, STATE, ZIP			
HOME PHONE		WORK PHONE		CELL PHONE #		PREFERRED PHONE #	
MARITAL STATUS	STUDENT STATUS ❐ PT ❐ FT	PHARMACY #		PRIMARY PHYSICIAN		REFERRING PHYSICIAN	
EMAIL ADDRESS				CAN WE EMAIL ❐ YES ❐ NO	CAN WE TEXT * ❐ YES ❐ NO	CAN WE LEAVE VOICEMAIL ❐ YES ❐ NO	
EMERGENCY CONTACT NAME:				PHONE #		RELATION TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY #
NAME OF SUBSCRIBER	EMPLOYER NAME		GROUP #
BIRTHDATE OF SUBSCRIBER	SS #	RELATIONSHIP	

SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY			POLICY #
NAME OF SUBSCRIBER	EMPLOYER NAME		GROUP #
BIRTHDATE OF SUBSCRIBER	SS #	RELATIONSHIP	

**Text messaging rates will apply.*

Release of Information

I hereby consent to Columbia Heart's use and disclosure of any medical information concerning me that is necessary for my treatment, for Columbia Heart to secure payment for its services rendered to me, and for other healthcare business operations. Such uses and disclosures may include releasing information requested by my insurance company, other physician's offices, hospitals or workers compensation insurers. I also consent to Columbia Heart obtaining medical information from other physician's offices and hospitals such as necessary for it to provide services to me.

Insurance Assignment

I hereby assign to the physicians of Columbia Heart all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. I certify that all information provided here is correct to the best of my knowledge.

Signature of Patient ______________________________ **Date** ____________________