PALMETTO PHYSICAL MEDICINE & CHIROPRACTIC

237 S. Herlong * Rock Hill, SC * (803) 325-2200

PATIENT HISTORY & REGISTRATION

PATIENT INFORMATION								
Date:								
Patient Full Name:	*(First)*			*(MI)*	*(Last)*			
Address:	*(Street)*				*(City)*	*(State)*	*(Zip)*	
Date of Birth:	*(mm/dd/yy)*	**Sex**	M	F	**Martial Status**	☐ Single ☐ Separated ☐ Married ☐ Divorced		
Social Security #:		**Occupation**						
Employer:					**Employer Phone:**			
SPOUSE INFORMATION								
Spouse Name:	*(First)*				*(Last)*			
Social Security #:					**Date of Birth:**			
CONTACT INFORMATION								
Home Phone:					**Best time to reach you?**			
Cell Phone:					**Best time to reach you?**			
IN CASE OF EMERGENCY, CONTACT								
Contact Name:	*(First)*				*(Last)*			
Contact Phone:					**Relationship:**			
INSURANCE								
Who is responsible for this account?	*(First Name)*				*(Last Name)*			
Relationship to patient?					**Insurance Co.:**			
Group #:					**Additional Insurance?**	☐ Yes ☐ No		
Insured Name	*(First Name)*				*(Last Name*			
Relationship:					**Date of Birth:**			
Social Security #:								
Insurance Co.:					**Group #:**			

Patient Signature:	**Print Name:**

PALMETTO PHYSICAL MEDICINE & CHIROPRACTIC

237 S. Herlong * Rock Hill, SC * (803) 325-2200

PATIENT HISTORY & REGISTRATION

ACCIDENT INFORMATION					
Date:					
Patient Full Name:	*(First)*		*(MI)*	*(Last)*	
Is condition due to an accident?	☐ Yes ☐ No	**Date of accident**		**Type of accident:**	☐ Auto ☐ Motorcycle ☐ Work ☐ Other
PATIENT CONDITION					
Reason For Visit:					
What area is bothering you?					
Type of pain you are experiencing. Check all that apply.	☐ Sharp ☐ Dull ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other				
Is this pain getting worse?	☐ Yes ☐ No	**How often do you have this pain?**		**Is it constant or does it come and go?**	
HEALTH HISTORY					
What treatments have you already received for your condition?					
Medications					
Surgery					
Physical Therapy					
Other			**Are you pregnant?**	☐ Yes ☐ No	
Name & Address of other Doctor(s) who have treated you					
MEDICATIONS					
What type(s) of medication are you currently taking?					
Do you have any allergies?	☐ Yes ☐ No	**Explain**			
Contact Phone:			**Relationship:**		

Patient Signature:	**Print Name:**

PALMETTO PHYSICAL MEDICINE & CHIROPRACTIC

237 S. Herlong * Rock Hill, SC * (803) 325-2200

MAJOR MEDICAL PAYMENT POLICY

Final responsibility for payment of medical services always lies with the patient or in the case of a dependant; the person who is legally responsible for that patient's medical bills. Palmetto Physical Medicine agrees to file and provide any third party healthcare payor any requested information, however, in the case of denial of benefits for any reason, the patient is responsible for payment in full of any medical bill incurred at Palmetto Physical Medicine.

If you have health insurance through your place of business or a private account with them, the contact is between YOU and YOUR INSURANCE COMPANY. It is the patient's responsibility to compel the insurance company to pay according to the patient's individual contract with them. We will provide you with any requested assistance in the collection of your account; but collection of payment by the insurance company remains the responsibility of the patient.

I, _____, am responsible for _____'s
(Financially responsible party) *(Patient's name)*
Medical expenses. I have agreed to allow Palmetto Physical Medicine to file my major medical health insurance on my behalf. I agree that direct payment for my medical services rendered at Palmetto Physical Medicine is to be paid directly to the facility. I also agree that any remaining balance or any balance or any balance occurring from a denial of payment by my insurance company is my responsibility.

By signing this policy I am indicating that the payment policy of Palmetto Physical Medicine has been explained to me and that I can fully understand it. I have also been made aware that Palmetto Physical Medicine can demand, in part or full, the total balance of my account at any time. I also agree to pay any and all collection expenses of this account if it becomes delinquent (delinquent is defined as being outstanding after 30 days subsequent to services) including a reasonable attorney's fee if necessary.

Signature:_____ Date:_____

Witness:_____ Date:_____

My signature below signifies that co-payment for medical/chiropractic services would constitute a financial hardship for me.

Signature:_____ Date:_____