SOUTH CHARLOTTE GENERAL & VASCULAR SURGERY, PLLC.

10512 Park Rd. Suite 111 Charlotte, North Carolina, 28210 Phone: 704-910-8380 Fax: 704-817-9980

DEMOGRAPHICS

Name:_____ Social Security #: _____

Date of Birth: _____ □ Single□ Married □Widowed □Separated □Divorced

Address: _____ City:_____

State: _____ Zip: _____

Email: _____

CHECK BOX IF BEST CONTACT # : □ Home _____

□ Cell _____ □ Work _____

Name of Spouse or Responsible Party: _____

EMERGENCY CONTACT: Name - _____

Relationship to patient- _____ Telephone #- _____

Patient Employer: _____

Occupation: _____

Pharmacy Name, Location & Phone Number: _____

ALLERGIES:

_____

Referring Doctor: _____

Primary Care Doctor: _____

INSURANCE (only fill out if you are a dependent)

Primary Insured Members Name: _____ Relation: _____

Date of Birth: _____ SSN: _____

Assignment of Benefits and Release of Information

I hereby authorize payment directly to the Physician for all medical benefits, if any, otherwise payable to me for services rendered, realizing I am responsible to pay for non-covered services. I authorize the physician to release any information in the course of my treatment necessary to process insurance claims.

_____ _____

Signature Date