



Palmetto Podiatry /JOHN R. MARINO, DPM, FACFAS

3510 US Hwy 17 North, Suite 110, Mt. Pleasant, SC 29466 (843-881-9159)

Patient Information

Referred By: _____

Last Name: _____ Mr. Mrs. Miss Other _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ___/___/___ Age _____ SSN: _____ - _____ - _____

Middle Name: _____ Preferred Name: _____ Primary Language: _____

Marital Status: Married Single Separated Divorced Widowed Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or OPI White

Student Status: Full Part N/A School: _____ Employment: Full Part N/A Employer: _____

ADDRESS: _____ City: _____ County _____ State: _____ Zip: _____

Email Address: _____

Phone: Home () _____ Work () _____ Cell: () _____

May we leave a voice message to remind you about appointments at your home or cell phone number? Yes _____ No _____

May we leave a voice message for normal test results at your home or cell phone number? Yes _____ No _____

(Complete only if you want the Practice to contact you at an address/phone different than you gave above)

Other Address: _____ City: _____ State: _____ Zip: _____ Other Phone () _____

Pharmacy Name and Phone Number: _____

Emergency Contact Name _____

Relationship _____ Home Phone () _____ Work Phone () _____

GUARANTOR / Responsible Person (if different from patient)

Last Name: _____ Mr. Mrs. Miss Other _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ___/___/___ Age _____ SSN: _____ - _____ - _____

Middle: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home () _____ Work () _____ Cell: () _____

Guarantor Email Address: _____

Primary Insurance

Secondary Insurance

Insurance Company: _____

Insurance Company: _____

Policyholder Name: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth: _____

Policy Holder Date of Birth: _____

Insurance Co. Phone Number: (_____) _____

Insurance Co. Phone Number:(_____) _____

Group # _____

Group # _____

Insurance Co. Address: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Ongoing Communication Regarding Your Healthcare

We may release/discuss your health information with the following people or organizations for the following dates of service, range of time, or event(s):

From (MM/DD/YY) _____ To (MM/DD/YY) _____

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate Authorization to Release Information Form must be completed if the information being released is different for these people or organizations listed above.

Authorization, Assignment of Benefits, and Referral Medical Release

I allow this Practice to use and release my protected health information for treatment, payment and healthcare operations as allowed by HIPAA and as described in the Roper St. Francis Healthcare Notice of Information Practices. I have been provided a copy of the Roper St. Francis Healthcare Notice of Information Practices.

I allow the release of medical information including complete medical records, test results, and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment.

I request the following restrictions on the use of my information: _____

I allow payment made directly to Roper St. Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this practice and my physician informed of changes to any of my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: _____

Patient Signature: _____

Date ____/____/____

Print Guardian's Name: _____

Guardian Signature: _____

Date ____/____/____

Office Use Only: