

# Eastern Carolina Internal Medicine, PA

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Patient Name (Last, First, MI)		Date of Birth / /	Social Security Number - -
Mailing Address (PO Box, City, State, Zip)		Sex F M	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Child <input type="checkbox"/> Separated
Physical Address (Street, city, State, Zip)		Home Phone Number ( ) -	Race <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian Other _____
Employer (Name and Address)		Work Phone Number ( ) -	
Spouse (Name)	Spouse SSN - -	Spouse's Date of Birth / /	How did you hear about us? <input type="checkbox"/> Phonebook <input type="checkbox"/> Radio <input type="checkbox"/> Billboard <input type="checkbox"/> Friend <input type="checkbox"/> Website <input type="checkbox"/> Referral Other: _____
Spouse's Employer (Name and Address)		Spouse's Work Phone Number ( ) -	
Who to contact in an Emergency (name, phone number, relationship)		E-mail Address	Is this a work related injury? <b>Y N</b>

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**NOTE TO DIVORCED PARENTS:** It is the policy of this office that the parent accompanying a child for treatment will be held responsible for all bills. We cannot bill non-present parent. Please provide information on both parents. List parent who is registering the child as the guarantor.

Guarantor Name (Last, First, MI)		Date of Birth / /	Social Security Number - -
Mailing Address (PO Box, City, State, Zip)		Sex F M	Home Phone Number ( ) -
Employer (Name and Address)		Work Phone Number ( ) -	
Other Parent Name (Last, First, MI)		Date of Birth / /	Social Security Number - -
Mailing Address (PO Box, City, State, Zip)		Sex F M	Home Phone Number ( ) -
Spouse's Employer (Name and Address)		Work Phone Number ( ) -	

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**Please have all insurance cards available to be copied**  
**Primary Insurance Coverage**

Policyholder (Last First, MI)		Date of Birth / /	Sex F M	Social Security Number - -
Spouse's Employer (Name and Address)		Policyholder's relationship to patient		Effective Date / /
Insurance ID	Group #	Plan #	Employer	
Address (PO Box, City, State, Zip)			Phone Number ( ) -	

