Family Physicians of Spartanburg

Date:	**Your physician name:**
Name of your pharmacy:	

Patient Information

Last Name			**First Name**		
Middle Initial			**Alternate Name?**		
Mailing Address			**Birth Date**		
Suite/Apt #			**Sex (M/F)**		
City			**Marital Status**		
State		**Zip Code**		**Social Security #**	
Home Phone #			**Cell Phone #**		
Work Phone		**Email**		**Student? (Y/N)**	
Preferred Method of Contact (Please check one)		**Home**		**Cell**	**Work**
Employer					
Race (Circle One) American Indian or Alaska Native / Asian / Native Hawaiian / Black or African American / White / Hispanic / Other Race / Other Pacific Islander / Refuse to Answer					
Ethnicity (Circle One) Hispanic or Latino / Not Hispanic or Latino / Refuse to Answer					
Emergency Contact			**Relationship**		
Emergency Phone			**Emergency Address**		

Guarantor Information (Person Responsible for Bill – Enter "same" if identical to above)

Last Name			**Social Sec. #**		
First Name			**Birth Date**		
Middle Initial			**Sex (M/F)**		
Marital Status			**Student (Y/N)**		
Street Adress		**Home Phone**			
Suite/Apt. #		**Cell Phone**		**Work Phone**	
City		**State**		**Zip Code**	
Email					
Guarantor Employment Information					
Employer Name			**Employer Phone**		

Insurance Information for Patient – Please Complete and Sign

PRIMARY INS	**Policy #**		**Name of Policy Holder:**
	Group #		**SSN:**
	Patient Relationship to policy holder:		**Birthday of policy Holder:**
	Policy Holder Employer		
SECONDARY INS	**Policy #**		**Name of Policy Holder:**
	Group #		**SSN:**
	Patient Relationship to Policy Holder :		**Birthday of Policy Holder:**
	Policy Holder Employer		

Signature of Patient/ Legal Guardian: _____