The Diabetes Center
11891 Plaza Drive
Murrells Inlet, SC 29576
(843) 353-0288

Patient Information

Last Name:	First Name:	Middle Name:	Sex:	Date of Birth:

Home Phone:	Day Phone:	Cell Phone:	Social Security Number:	Marital Status:

Race (please select one):

o American Indian or Alaska Native **o** Asian **o** Black or African American

o Native Hawaiian or other Pacific Islander **o** White **o** Other

Ethnicity (please select one):	Language:
o Hispanic or Latino **o** Not Hispanic or Latino	

Billing Address (if applicable):	City, State, Zip:

Primary Care Physician:	Referring Physician:	Emergency Contact Name:	Contact's Phone Number:

Email Address:

Responsible Party Information (if different from above)

Name (Last, First Middle):	SSN:	Birthdate:	Language:	Sex:

Address:	City, State, Zip:

Phone:	Relationship to Patient:

Primary Insurance

Name of Insurance Company:	Subscriber SS#	Policy Number:

Name of Subscriber	Subscriber Date of Birth:	Group Name/Number:

Relationship to Subscriber:	Effective Date:	Employer:

Secondary Insurance (if applicable)

Name of Insurance Company:	Subscriber SS#	Policy Number:

Name of Subscriber	Subscriber Date of Birth:	Group Name/Number:

Relationship to Subscriber:	Effective Date:	Employer:

I agree that all of the information provided above is true and accurate. I also agree that benefits may be filed on my behalf for all services provided by The Diabetes Center with my signed authoization below. I understand that my signed authorization regarding this information and release of benefits is only applicable for one calendar year from the date below.

Signed: _____ Date: _____

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We are interested in learning how you made the decision to come to our office. Please select from the following options. More than one option may be selected if appropriate.

- ☐ Yellow Pages
- ☐ Billboard
- ☐ Radio Advertisement
- ☐ TV Advertisement
- ☐ Recommended by a friend or relative: _____
- ☐ Referred by a physician: _____
- ☐ Newspaper or print ad: _____
- ☐ Other (please give details: _____

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Name: _____ Date of Birth: _____

(Please Print)

PRIVACY NOTICE

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we must have your signed permission to leave any information with anyone other than you.

If you would like us to discuss your medical information with any person other than yourself, or give that person medical information, you must designate that person or persons below:

1. Name:_____Relationship:_____
2. Name:_____Relationship:_____
3. Name:_____Relationship:_____

Would you like us to leave information about your future appointments on your answering machine?

☐ YES ☐ NO

Signature: _____ **Date**: _____

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Philip R. Nicol, MD
Vesna Solheim, MD
11891 Plaza Drive, Murrells Inlet, SC 29576
Phone (843) 353-0288 Fax (843) 357-9770

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____ **Last 4 Digits SS#: XXX-XX-_____**

I HEREBY AUTHORIZE:

Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone #:_____ Fax: _____

INFORMATION TO BE RELEASED:	**DATES**
•History and physical exam:	_____
•Progress notes	_____
•Lab Reports:	_____
•X-Ray Reports:	_____
•Other:	_____

PURPOSE OF DISCLOSER:

☐ Changing Physicians ☐ Consultation/2nd Opinion ☐ Continuity of Care

☐ Legal/School ☐ Insurance ☐ Workers Compensation

☐ Other (please specify): _____

1.I understand that this authorization will expire 30 days after I have signed the form.

2.I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

3.I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.

4.I understand that I am being requested to release this information by The Diabetes Center for the purpose of _____
_____

a.By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
b.I understand I may see a copy of the information described on this form if I ask for it and that I will get a copy of this form after I sign it if I ask for it.

_____ _____
SIGNATURE OF PATIENT DATE