

# Metrolina Medical Associates

2670 Mills Park Drive, Suite 200

Rock Hill, SC 29732-8599

(803) 985-3939

## PATIENT INFORMATION

Name (Last, First, MI)		SSN	Birthdate	Sex
Local Address (if PO Box, please include physical address, as well)			City, State, Zip	Home Phone
Cell Phone	Work Phone	Email Address		Marital Status
Student Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time	Smoker?	Veteran?	Emergency Contact Name	Emergency Contact Phone
Race (circle one) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Multiracial <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native Hawaiian/Pacific Islander		Language (circle one) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other		Ethnicity (circle one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Preferred Method of contact (circle one): Home Phone      Cell Phone      Work Phone      Email      Other (specify): _____				
Employer		Employer Address		Work Phone

## RESPONSIBLE PARTY INFORMATION (If different from above. This does not change legal responsibility)

Name (Last, First, MI)		SSN	Birthdate	Sex
Local Address (if PO Box, please include physical address, as well)			City, State, Zip	
Home Phone	Cell Phone	Work Phone	Email Address	Relationship to Patient

## PRIMARY INSURANCE

Name of Insurance Company		Policy ID #	Group #
Address of Insurance Company		City, State, Zip	Insurance Phone
Effective Date	Copay Amt	Deductible	Name of Insured
Insured Birthdate	Insured SSN		Insured Employer

## SECONDARY INSURANCE (If applicable)

Name of Insurance Company		Policy ID #	Group #
Address of Insurance Company		City, State, Zip	Insurance Phone
Effective Date	Copay Amt	Deductible	Name of Insured
Insured Birthdate	Insured SSN		Insured Employer

**BY SIGNING THIS, I AGREE THAT THE INFORMATION ABOVE IS TRUE AND ACCURATE.**

\_\_\_\_\_  
SIGNATURE OF PATIENT/GUARDIAN

\_\_\_\_\_  
DATE