

CAROLINA WOMEN'S RESEARCH AND WELLNESS CENTER

DR. ANDREA LUKES

NEW PATIENT INFORMATION SHEET

For Office Personnel Use Only:

Please obtain copies of all insurance cards or all relevant information from the patient, and obtain the referring physician information.

Referring Physician (Primary): (name) _____ (city/state) _____ (UPIN) _____

Referring Physician (Secondary): (name) _____ (city/state) _____ (UPIN) _____

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name (First, M.I., Last):	SSN:	Sex: M / F
Address: (street)	DOB:	Age:
(city) (state) (zip)	Tel No: (H)	(W)
Employer:	Driver's License / State:	
Employer's Address:	Marital Status: S M W D	
Referring Physician:	If Student, School Name:	Full / Part Time
Friend or Relative Not Living with You and phone number:		

RESPONSIBLE PARTY / GUARANTOR INFORMATION

**** NOTE: If patient is the responsible party / guarantor, enter "SELF" and go to primary insurance information. ****

Name (First, M.I., Last):	Social Security #:	Sex: M / F
Address: (street)	Date of Birth:	Age:
(city) (state) (zip)	Phone #:	Work #:
Employer:	Driver's License / State:	
Employer's Address:	Relationship to Patient:	

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Payer / Insurance Name:	Payer / Insurance Name:
Claims Address: (street)	Claims Address: (street)
(city) (state) (zip)	(city) (state) (zip)
Payer / Insurance Phone:	Payer / Insurance Phone:
Group #: Certificate/ID #:	Group #: Certificate/ID #:
Policy Holder's Name: Sex: M / F	Policy Holder's Name: Sex: M / F
Policy Holder's SS#: Birthdate	Policy Holder's SS#: Birthdate
Relationship to Patient: Self / Spouse / Dependent	Relationship to Patient: Self / Spouse / Dependent
Policy Holder's Employer:	Policy Holder's Employer:
Employer's Address: (street)	Employer's Address: (street)
(city) (state) (zip)	(city) (state) (zip)

PATIENT MEDICAL RECORDS RELEASE STATEMENT

I hereby assign, transfer, and set over to DR. ANDREA LUKES all of my rights, title, and interest to my medical reimbursement benefits under all my insurance policies. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. However, if DR. ANDREA LUKES is in a direct contract with my third-party insurance payer, the financial responsibility provisions of the contract between my insurance payer and DR. ANDREA LUKES will determine my ultimate financial responsibility.

Patient's Signature _____	Date _____
Responsible Party / Guarantor (if applicable) _____	Date _____