Cross Island Medical Center

Call or Visit Us
843-681-8260
157 William Hilton Parkway
Hilton Head Island, SC 29926

PATIENT REGISTRATION FORM

Patient Last Name First Middle (full) Maiden

Mailing Address: _____City: _____ ST: _____ ZIP: _____

Street Address: _____City: _____ ST: _____ ZIP: _____

Social Security #: _____ DOB:___/___/___ Age: _____ Sex: _____ M _____ F

Marital Status (circle one): S M W D SEP

Employer: _____ Address: _____Phone #: _____

Spouse/Parent/Guardian: _____ Social Security#: _____ DOB: _____

MEDICAL INSURANCE INFORMATION ***(A copy of your insurance card and a picture id must be in our file)***

Primary Company	**Policy Holder**	**DOB**	**Policy #**	**Group #**
Secondary Company	**Policy Holder**		**Policy #**	**Group #**

INSURANCE AUTHORIZATION:

I hereby authorize Cross Island Medical Center to furnish information to my insurance carriers concerning my illness and treatments, and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by my insurance.

Print Name: _____ Date: _____

Signed: _____ Date: _____

Nearest friend or relative *NOT RESIDING* with you that we can contact in the event of an emergency.

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Who may we thank for referring you to us: _____

It is customary to pay for all services when rendered. All professional services when rendered are charged to the patient. This office will file for insurance benefits in plans which we may participate. Necessary information will be supplied to the patient to enable them to file their insurance for other plans. However, the patient is responsible to this office for all fees, regardless of insurance coverage, and also collection expenses and/or reasonable attorney fees.

I have read and understand the above: _____ Date:_____