Family Physicians of Spartanburg

Welcome to our Practice

Account #		Your physician name?	
Name of your pharmacy?			

Patient Information

Last Name		First Name			
Middle Initial		Alternate Name?			
Street 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)	
Employer					
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			
Street Address		Suite/Apt #			
City		State			
Zip Code		County			

Insurance Information for Patient – Provide Complete or provide copy of insurance card

Insurance Company #1	Policy #	Name of Insured:
	Group #	SSN:
	Relationship to Insured:	Birthday of Insured:
Insurance Company #2	Policy #	Name of Insured:
	Group #	SSN:
	Relationship to Insured:	Birthday of Insured:
Insurance Company #3	Policy #	Name of Insured:
	Group #	SSN:
	Relationship to Insured:	Birthday of Insured:

Signature of Patient/Guardian: ____