

**APPLICATION FOR MEDICAL CARE**  
**Thomas Heischmidt M.D.**  
**PATIENT INFORMATION SHEET**

(PLEASE PRINT CLEARLY)

Have you been seen previously by: \_\_\_\_\_ Dr. Brummer \_\_\_\_\_ Dr. Bingham \_\_\_\_\_ Dr. Heischmidt  
Application for  family  individual Date of Application \_\_\_\_\_

Guarantor's Full Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
LAST FIRST MIDDLE

Previous/Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_  Married  Single  Divorced  Separated  Widowed

Social Security No.: \_\_\_\_\_ Driver's License No.: \_\_\_\_\_

Guarantor's Employer: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Ext.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

Spouse: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Ext.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

Present Physician: \_\_\_\_\_ Referred By: \_\_\_\_\_

In case of emergency, contact (Other than spouse): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Ext.: \_\_\_\_\_

Children's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Sex \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Sex \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Sex \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Sex \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Sex \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Coverage, Name of Carrier & Address \_\_\_\_\_

Effective Date: \_\_\_\_\_ Group No. \_\_\_\_\_

Identification No.: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_\_

Are you covered by Medicare?  Yes  No Medicare No.: \_\_\_\_\_ Railroad?  Yes  No

Are you covered by Medicaid?  Yes  No Medicaid No.: \_\_\_\_\_

**We ask all patients to show their insurance membership card so that we may copy them. Medicaid Card must be presented at each visit or payment is due the day of service.** We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment.

I hereby authorize **Family Care Associates of Effingham, S.C.** to file claims and/or make inquiries in my behalf, accept assignment, and provide information regarding my care and treatment to my insurance carrier. I have been informed and understand that I am personally responsible for the full payment of my account. In the event my account is past due more than 60 days, a finance charge will be assessed. If I have not made arrangements for payments after 120 days, I will be responsible for all fees incurred for collection and/or attorney fees.

We require payment, and/or co-payment, the day of service for all office visits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Have you applied here before?  Yes  No