Welcome to Palmetto Cardiology/York Co

Please help us by providing the following information:

Name:____ DOB:________

Address:____

City: ________________________ State:____________ Zip Code: __________

Home Telephone: Area Code____ _____________Mobile: ___ ____________

Male:______ Female______

Next of Kin: ________________________ Relationship: ____________________

Contact information: ____

Please enter a daytime # or address on the above line.

Pharmacy Name and Tel: ___________________ (or street address)____________

Primary Care Physician's Name____

and address ____

Referring Physician's Name (if different)_____________________________________

Insurance Information:

Primary Coverage: ____

Policy Holder Name____

Policy Holder's Date of Birth___________ and SS #_________________________

Secondary Coverage: ____

Policy Holder name____

Policy Holder's Date of Birth:___________and SS#__________________________

Have you met your deductible for the year? ___yes ___no