

# CAROLINA MEDICINE, PC

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Robin A. Whitten, PA-C

Welcome to our practice. Please complete this form so we may set up your patient record. Thank you.

Please Print Clearly

PATIENT NAME

DATE \_\_\_\_\_

\_\_\_\_\_  
(First)

\_\_\_\_\_  
(Middle)

\_\_\_\_\_  
(Last)

HOME ADDRESS

MAILING ADDRESS

\_\_\_\_\_  
Street and/or Apartment Number

\_\_\_\_\_  
Street and/or Apartment Number

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Home Telephone Number

\_\_\_\_\_  
Work Telephone Number

\_\_\_\_\_  
Date of Birth Male  Female

\_\_\_\_\_  
Married  Single  Widowed  Divorced

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Previous/Current Physician or Medical Group

PERSON RESPONSIBLE FOR ACCOUNT

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home Telephone Number

\_\_\_\_\_  
Work Telephone Number

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Employer

PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_ PHONE # \_\_\_\_\_

INSURANCE INFORMATION

\_\_\_\_\_  
Name of Insurance company

\_\_\_\_\_  
Cardholder's Social Security Number

\_\_\_\_\_  
Cardholder's Date of Birth

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Additional Insurance: Company Name

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Group Number

**PAYMENT IS EXPECTED AT THE TIME OF SERVICE. THANK YOU.**

**Method of Payment:** Cash  Check  Credit Card

**AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO SANFORD PRIMARY CARE CENTER**  
I hereby authorize Sanford Primary Care Center to release information acquired in the course of my examination and treatment. I hereby assign payment directly to Sanford Primary Care Center for any medical or surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Signature: \_\_\_\_\_ (Parent or guardian if patient is a minor)