



Dr. H. Kevin Jones
1251 B. Ribaut Rd.
Beaufort, SC 29906
(843) 524-3015

Patient's Name: _____

_____ (Last) _____ (First) _____ (MI)
D.O.B.: _____ Age: _____ Sex: _____ SSN#: _____

Marital Status (check one): S M W D Home Phone # _____

Work Phone # _____ Cell Phone # _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Spouse's Name: _____

_____ (Last) _____ (First) _____ (MI)

Insured Employer: _____ Work Phone #: _____

Employee Address: _____

City: _____ State: _____ Zip: _____

Insured SSN#: _____ Insured D.O.B.: _____

Primary Health Insurance: _____

Policy #: _____ Group #: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Secondary Health Insurance: _____

Policy #: _____ Group #: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Is this Workman's Comp? _____ Is an Attorney involved? _____

Referred By: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact Person: _____ Phone #: _____

Assignment of Benefits. I hereby authorize direct surgical/medical benefits to Lowcountry Bone and Joint Specialists or its Physician for services rendered by them or under their supervision. I understand that I am financially responsible for any co-pays, deductibles, or co-insurance, not covered by my insurance. I hereby authorize Lowcountry Bone and Joint Specialists and staff members to release any medical or incidental information that may be necessary for other medical care or in processing applications for financial benefits.

Patient/Guarantor: _____ Date: _____

(Signature)