FASTER CARE PATIENT INFORMATION

1. Last Name____________________First Name______________________
2. Address:____
3. City, State, Zip:____
4. Phone:________________________DOB:_______________Age:_______
5. Weight:__________ Height:___________
6. Who is your regular doctor?____________________________________
7. What pharmacy do you want to use today?_________________________
This will be the pharmacy you use today. NO EXCEPTIONS

8. **Will you need a work or school note?** Circle: **WORK SCHOOL NONE**

9. What is your chief complaint today and when did it start:

____

10. List symptoms:____

____

11.Do you have any medical conditions? **Circle: YES or NO** If yes, please list:

____

____

____

12. Are you allergic to any medications? **Circle: YES or NO** If yes please list:____

____

13. Do you take any medications? **Circle: YES or NO** If yes, please list names of each: ____

____

____

14. Have you ever had any surgeries: **Circle: YES or NO** If yes, please list:

____

____

15. Have you ever been hospitalized? **Circle: YES or NO** If yes, please list reason:

____

____

____

16. Date of Last Tetanus:_______________________

If applicable, are your child's immunizations up to date? **YES or NO**

Office Use: Time:

Ins:

Pre-auth: Y or N

BP:	BP:
P:	P:
R:	R:
T:	T:
O2:	O2:

OFFICE USE, LEAVE BLANK.

17. **Women:** Date of last period?____________________ Are you pregnant or nursing? **YES or NO**__________________

18. **Please list hereditary medical conditions of people listed regardless if alive or deceased:**
Father: [_] alive [_] deceased____

Mother: [_] alive [_] deceased____

Siblings: [_]alive [_] deceased____

Children: [_] alive [_] deceased____

19. Do you have someone to make medical decisions on your behalf should you become unable to make the decisions for yourself? **YES or NO** Name:______________________________Phone:__________________________________
Address:____

20. Do you ☐ smoke ☐ use smokeless tobacco ☐ vape ☐ none

If yes, how much/how often per day?____

-Use illegal drugs/substances? **YES or NO** If yes, what and how much? _____________________

-Do you drink alcohol? **YES or NO** If yes, please answer the following:
***How often did you drink alcohol this past year?

[ ]Never **[ ]Monthly or less** **[ ] 2-4 a month** **[ ]2-3 a week**

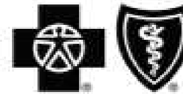
***How many drinks did you have on a typical day when you were drinking?

[ ]1-2 **[ ]3-4** **[ ]5-6** **[ ]7-8** **[ ]10 or more**

***How often did you have 6 or more drinks on one occasion in the past year?

[ ]Never **[ ]less than monthly** **[ ]Monthly** **[ ]Weekly** **[ ]Daily or almost daily**

Subrogation / Workers' Compensation
I-20 at Alpine Road
Columbia, SC 29219-0001
1-800-288-2227, extension 43060
Fax: 1-803-865-0654



South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

ACCIDENT QUESTIONNAIRE

Subscriber: ____________________
Address: ____________________
Address: ____________________

Patient: ____________________
Identification No.: ____________________
Provider: ____________________
Date of Service: ____________________
Group Number: ____________________
Claim Number: ____________________
Claim Amount: ____________________

Dear Member:

Our review process indicates this patient may have received healthcare services related to an accident. So we may evaluate our responsibility, please complete, sign and return this form within five days of receipt. If we do not receive this information, we may have to deny your claims. **If you have previously completed a form for this accident, please check here _____ and update.**

Was the injury or illness: **Auto/Motorcycle Accident____ Work Related____ Other Accident____ No Accident _____**
Date of the injury or illness: ____________________ City/County and State of Injury: ____________________
Describe the injury or illness and how it happened: ____________________
____
Names of other family members injured: ____________________

If you checked "Auto/Motorcycle Accident" or "Other Accident," please answer the following:
Did another person cause this accident? YES / NO
If yes, name and address of person causing injury: ____________________
Insurance Company of person causing injury: ____________________ Policy/Claim # : ____________________
Address and Phone #: ____________________ Adjuster's Name: ____________________
If auto or motorcycle related, was the patient wearing a seatbelt? YES / NO a helmet? YES / NO
If auto or motorcycle related, was the patient the driver ________ or a passenger ________ ?
Auto Insurance Company of Patient: ____________________ Policy/Claim #: ____________________
Address and Phone #: ____________________ Adjuster's Name: ____________________

If you checked "Work Related," please answer the following:
Name and address of patient's employer at the time of injury: ____________________
Have you filed a Workers' Compensation claim? YES / NO
If yes, name of Workers' Compensation carrier: ____________________
Policy/Claim # : ____________________ Adjuster's Name: ____________________
Address and Phone # ____________________
Has the employer or the workers' compensation carrier accepted or denied liability? ACCEPTED / DENIED

Name, address, and telephone number of your attorney (if applicable): ____________________
____

I agree that the above information is correct, and I will not settle a claim before contacting the Subrogation / Workers' Compensation Department of BlueCross BlueShield of South Carolina.

____
Signature Date Telephone Number

Visit our website at:
www.SouthCarolinaBlues.com

OTHER HEALTH/DENTAL COVERAGE QUESTIONNAIRE

Your contract contains a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan. We need information about possible other health/dental coverage, including Medicare, to process your claims correctly.

Patient Name: ______________________ ID Number: ______________________

Address: ______________________

______________________ Date: ______________________

1. Do you or any dependents have any other group health, dental or Medicare coverage? ☐ No ☐ Yes

IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM OR CALL US AT OUR COB HOTLINE (800-931-3401) AND WE WILL PROCESS THIS INFORMATION IMMEDIATELY. IF YOU ANSWERED YES, PLEASE PROCEED TO QUESTION #2.

Your Signature: ______________________ Date: ______________________

2. Please list the family members covered by the other policy and the type of coverage you have.

______________________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare

For additional family members, attach a separate sheet with the information.

* **If you checked Medicare, answer question #7 on page 2.**

3. Name of Other Policyholder: ______________________

Other Policyholder's Date of Birth: ______________________ Relationship to You: ______________________

4. Employer's Name, If Coverage is Provided Through an Employer: ______________________

5. Name of Other Insurance Company and Effective Date of Policy: ______________________ Effective Date: ______________________

If policy is now terminated, please give termination date: ______________________ ID#: ______________________

6. The Other Insurance Company's Address: ______________________

7. The Payor ID for the Other Insurance Company (if known): ______________________

8. If there is a divorce or separation, please list who is responsible for the health care expenses: ______________________

If there is a copy of a divorce decree, please forward a copy to us.

If there is not a court decree, who has custody of the children? ______________________

7/2017