



- Charleston
- Georgetown
- Columbia
- Beaufort

Patient Name: _____ DOB: _____

SSN: _____ Parent(s) name (If under 18): _____

Address: _____

City: _____ State: _____ Zip: _____

Cell # _____ Is it ok to leave detailed message on voice mail? Yes ___ No ___

Alternate # _____

Primary Insurance: _____ Employer: _____

Policy Holder: _____ DOB: _____ SS#: _____

Policy #: _____

Group #: _____ Prescription Plan: _____

Pharmacy: _____ Phone #: _____

PCP: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Current Sickle Cell Doctor: _____ I don't have one

Circle type of Sickle Cell: SS SC Beta Thalassemia O Arab I don't know

Thank you for trusting your patient's care to the team at Lifespan Comprehensive Sickle Cell Center.
Forms may be returned by fax to: 843-876-8519