PATIENT INFORMATION (Please print)

PATIENT:

FIRST NAME_____MI_____LAST NAME_____

STREET ADDRESS_____

MAILING ADDRESS (IF DIFFERENT)_____

CITY_____STATE_____ZIP_____PHONE_____/_____

DATE OF BIRTH_____SEX (M/F)_____SOCIAL SECURITY NUMBER_____

MOTHER'S NAME_____DATE OF BIRTH_____

SOCIAL SECURITY NUMBER_____HOME PHONE NUMBER_____

ADDRESS_____

CITY_____STATE_____ZIP_____

EMPLOYER_____PHONE NUMBER_____

ADDRESS_____

CITY STATE ZIP

FATHER'S NAME_____DATE OF BIRTH_____

SOCIAL SECURITY_____HOME PHONE NUMBER:_____

ADDRESS_____

CITY_____STATE_____ZIP_____

EMPLOYER_____PHONE NUMBER_____

ADDRESS_____

CITY STATE ZIP

PRIMARY INSURANCE COMPANY:_____

Member ID Number:_____ Group Number:_____

SUBSCRIBER OF INSURANCE:_____SSN:_____DATE OF BIRTH_____

RELATIONSHIP:_____EMPLOYER_____PHONE NUMBER_____

ADDRESS:_____

SECONDARY INSURANCE COMPANY:_____

Member ID Number:_____ Group Number:_____

SUBSCRIBER OF INSURANCE:_____SSN:_____DATE OF BIRTH_____

RELATIONSHIP:_____EMPLOYER_____PHONE NUMBER_____

ADDRESS:_____

EMERGENCY CONTACT_____

PHONE NUMBER_____RELATIONSHIP_____

OVER

MEDICAL INSURANCE INFORMATION:

WE MUST HAVE A COPY OF YOUR CURRENT INSURANCE CARD

I authorize payment of medical benefits to the physician or supplier for services rendered. I authorize the release of any medical information necessary to process insurance claims and certify the information contained herein is correct.

Except under certain circumstances (governmental programs such as TennCare or Medicaid; and physician participating health insurance plans), I will be responsible for the full amount of the charges. I agree to pay any collection fees if legal action is necessary in the collection effort of this account.

SIGNATURE_____DATE_____
__

RELATIONSHIP TO
PATIENT_____