PATIENT INFORMATION **(Please print)**

Referred By: _____

PATIENT:

First Name_____ MI _____ Last Name_____

Street Address _____

Mailing Address (If different) _____

City _____ State_____ Zip_____

Date of Birth _____ Sex (M/F) _____ Social Security Number _____

MOTHER'S NAME _____ Date of Birth_____

Social Security Number_____ Home Phone Number _____ Cell _____

Address _____

City _____ State _____ Zip_____

Employer_____ Phone Number _____

Address _____

City State Zip

FATHER'S NAME _____ Date of Birth_____

Social Security Number_____ Home Phone Number _____ Cell _____

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: _____

City State Zip

SECONDARY INSURANCE COMPANY: _____

Member ID Number: _____ Group Number: _____

SUBSCRIBER OF INSURANCE: _____ SSN: _____ Date of Birth _____

Relationship: _____ Employer _____ Phone Number _____

Address: _____

City State Zip

PLEASE COMPLETE INFORMATION ON BACK

EMERGENCY CONTACT: _____

Phone Number:_____ Relationship_____

My child may be accompanied by:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give permission for the physician to share any relevant health information with the person who is accompanying my child.

_____

Parent or Guardian Signature Parent or Guardian Name (Please Print)

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 neccessary in the collection effort of this account.

SIGNATURE_____ DATE _____

RELATIONSHIP TO PATIENT _____