TENNESSEE MEDICINE & PEDIATRICS, P.C.

PATIENT REGISTRATION

Date: _____

Patient Name _____

Sex ☐ M ☐ F Marital Status _____

DoB _____ SS# _____

Address _____

City _____ State _____ Zip _____

Home Phone (___) _____

Employer _____

Occupation _____

Work Phone (___) _____

Spouse Name _____

DoB _____ SS# _____

Address (if other than yours) _____

_____

City _____ State _____ Zip _____

Home Phone (___) _____

Employer _____

Occupation _____

Work Phone (___) _____

Responsible for Payment ☐ Self ☐ Spouse ☐ Other _____

Address (if other than yours) _____ City _____ State _____ Zip _____

Home Phone (___) _____ Work Phone (___) _____ SS# _____

Emergency Contact Person _____ **Relationship** _____ **Phone** (___) _____

Referred By _____

Primary Pharmacy Location _____ Phone _____ Fax _____

Insurance Information

Primary _____ Address _____

Policy No. _____ Group No. _____

Name of Insured _____ Relationship _____ DoB ___/____/____

Secondary _____ Address _____

Policy No. _____ Group No. _____

Name of Insured _____ Relationship _____ DoB ___/____/____

Medicare/Medicaid/Other _____ Current Card No. _____

Authorization of Treatment and Assignment of Benefit

I authorize Tennessee Medicine & Pediatrics, P.C. to treat me. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Tennessee Medicine & Pediatrics, P.C. for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that if my physician(s), or any person employed by or under the direction and control of my physician(s), is directly exposed to my body fluids in any manner which may, according to the current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

Patient Signature _____ Date _____

Witness _____ Date _____

Do You Have Any Advance Directive? (Living Will, And/Or Durable Power of Attorney for Healthcare) ☐ **Yes** ☐ **No**