TENESSEE WOMENS HEALTHCARE P.C. PATIENTS#_____

PATIENT INFORMATION FORM In order to serve you properly we need the following information.

TODAY'S DATE_____

REFERRED BY _____

GENERAL

PATIENT'S NAME_____BIRTHDATE_____

SOCIAL SECURITY_____-_____-_____MARITAL STATUS_____

ADDRESS_____APT # _____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE (_____)_____WORK PHONE (_____) _____

CELL PHONE (_____)_____PHARMACY (_____)_____

EMPLOYER_____ E-MAIL _____

PCP "FAMILY DOCTOR"_____ PHONE (_____)_____

IN CASE OF EMERGENCY NOTIFY_____PHONE _____

INSURANCE

PRIMARY INSURANCE_____ ID #_____

PRIMARY POLICY HOLDER: _____ DOB: _____

SS# _____ADDRESS: _____PHONE_____

RELATIONSHIP TO PT _____ IS THIS THROUGH EMPLOYER? _____EMPLOYER _____

SECONDARY INSURANCE Yes___ No __ Name _____

PRIMARY POLICY HOLDER _____ ID # _____

FINANACIAL

PATIENT IS RESPONSIBLE FOR OBTAINING REFERRALS & VERIFYING PRE-CERTS

I authorize payment of medical benefits to the physicians' names provided for professional services rendered. I authorize the release of any medical information necessary to process this claim. I understand that, in default of payment, I am responsible for all collection and attorney fees that will result from nonpayment. I understand that the percentage that my insurance does not cover needs to be paid when services are rendered.

Signature of patient _____ Date _____

If patient is a minor signature of parent or legal guardian _____

Print name _____ relationship to patient _____Date _____