

MEMPHIS MEDICAL SPECIALISTS ** PATIENT INFORMATION

ACCOUNT NUMBER

DATE: _____ TO SEE DR: _____

PATIENT NAME: _____ M _____ F _____
first middle last

S.S.#: _____ / _____ / _____ BIRTHDATE: _____ / _____ / _____ MARITAL STATUS: _____

ADDRESS: _____
street city state zip

HOME PHONE#: _____ CELL PHONE#: _____ WORK PHONE#: _____

EMPLOYMENT STATUS: Part Time Full Time Retired Non-employed
Self-employed Active Duty Unknown

STUDENT STATUS: Full Time
Part Time

EMPLOYER: _____ OCCUPATION: _____

NEAREST RELATIVE NOT LIVING WITH YOU:
name relationship phone number

DRUG ALLERGIES: _____ ADVERSE REACTIONS TO EACH : _____

NAME OF REFERRING DOCTOR: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

I.D.#: _____ GROUP#: _____

NAME OF POLICYHOLDER: _____ D.O.B. _____ / _____ / _____ S.S.# _____ / _____ / _____

INSURANCE ADDRESS: _____
street city state zip

*HMO/PPO/ PLANS:
NAME OF PRIMARY CARE PHYSICIAN: _____

SECONDARY INSURANCE: _____

I.D.#: _____ GROUP#: _____

NAME OF POLICYHOLDER: _____ D.O.B. _____ / _____ / _____ S.S.# _____ / _____ / _____

INSURANCE ADDRESS: _____
street city state zip

THIRD INSURANCE: Please check here if you have a 3rd or 4th insurance and fill out an additional sheet provided by the receptionist.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to my physician for benefits due me for his services. I understand that I am financially responsible for charges not covered by this insurance.

RELEASE OF INFORMATION: I hereby authorize the physician to release any information required to process any insurance claim.

AGREEMENT: In the event of default, I agree to pay all cost of collections including all reasonable attorney fees.

TREATMENT CONSENT: I hereby give my permission to receive services and treatment by my physician at MEMPHIS MEDICAL SPECIALIST (and/or associates).

SIGNED: _____ DATE: _____

Medicare patients with Medigap Insurance: I request that payment of authorized Medigap benefits be made on my behalf to Memphis Medical Specialists for any services furnished me by that supplier. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits. This authorization is in effect until I choose to revoke it.

Patient/Responsible party: _____ Date: _____

COPIES OF DRIVERS LICENSE AND ALL INSURANCE CARDS ARE NECESSARY AT THIS TIME.