PATIENT REGISTRATION

(Please Print Clearly)

Date_____

Account #_____ Have you been seen by any doctor in this group at any time?_____

Referral Dr._____ Referral Dr's. Office #_____

PATIENT INFORMATION

Name _____
(Last) (First) (Middle) (Maiden)

Address _____

City _____ State _____ Zip _____

Home Phone _____ **Cell Phone** _____ Age _____ Birthdate _____

Social Security # _____ Marital Status _____

Employer Name and Address _____

Work Phone _____ _____

RESPONSIBLE PARTY INFORMATION

Social Sec. # _____

Name _____
(Last) (First) (Middle) Birthdate _____

Address _____ Phone _____

City _____ State _____ Zip _____

Employer: _____ Phone _____

Relationship: _____

SPOUSE INFO

Name _____ Soc. Sec. #_____

Employer and Address _____

_____ Birthdate _____

Phone _____

(Please Provide Insurance Card For Us To Copy)

INSURANCE INFO

Primary Carrier _____

Insured's Name _____ Relationship _____

Name and Address of Carrier _____

_____

GP # _____ ID # _____

Other Insurance Social Sec. # _____

Insured's Name _____ Birthdate _____

Name and Address of Company _____

GP # _____ ID # _____

ADVANCED DIRECTIVES? YES_____ NO_____ OR A LIVING WILL?

MEDICARE WILL PAY FOR A BREAST AND PELVIC EXAM WITH OR WITHOUT A PAP SMEAR EVERY OTHER YEAR!

I authorize the release of any medical information necessary to process insurance claims.
I further authorize payment of medical benefits to the physician in the event they file for the insurance.
I understand that I am financially responsible for any balance not covered by my insurance company.

_____

Patient's or authorized individual's Signature Date

TELEPHONE PERMISSION

Where do you prefer to receive calls:

☐ Home Phone # _____ ☐ Mobile # _____

☐ Work Phone # _____ Extension # _____

Messages:

I _____agree to allow Middle TN Women's Health Group
(Print Name) (Date of Birth)
to leave a message (please check all that are acceptable).

☐ On my answering machine.

☐ With _____ (specify name and relationship).

☐ Exclusively with me.

Regarding:

☐ An appointment. ☐ Referrals

☐ Pending test results. ☐ RX Information

☐ Billing Information ☐ Other _____

This document will be considered valid unless a written revocation is received.

OTHER NUMBERS:

Family Doctor _____ Family Doctor's Office Number _____

Pharmacy _____ City _____Pharmacy's # _____

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payments. Please check which option you prefer.

☐ Cash ☐ Personal Check ☐ Credit Card (Visa/MasterCard)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices
(Please Print)
given to me by Middle Tennessee Women's Health Group.

Signed: _____ Date: _____

FOR OFFICE USE ONLY:

If not signed, reason why acknowledgement was not obtained: _____

_____

Person seeking acknowledgement: _____ Date: _____

FOR OFFICE USE ONLY:

HIPAA Privacy Policy: Has the patient acknowledged receipt of Middle Tennessee Women's Health Group Privacy Policy? ☐ Yes