

HOW DID YOU HEAR ABOUT US?

Patient Information

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ D.O.B.: _____
Sex: Male / Female SS#: _____ Marital Status: S / M / D / W
Employer Name: _____ Employment status: FT / PT / Retired / N/A

Emergency Contact

Contact Name: _____ Home Number: () _____
Relationship to Patient: _____ Work Number: () _____

Responsible Party If Not Patient

Name: _____ Date of Birth: _____
Social Security #: _____ Home Phone: () _____
Sex: Male / Female Mailing Address: _____
City, State, Zip: _____
Employer Name: _____ Employer Number: () _____
Relationship to Patient: _____

Insurance

Primary Ins Name: _____ Co-Pay: _____
Insured Name: _____ D.O.B.: _____
Social Security #: _____ Home Phone: _____
Sex: Male / Female Mailing Address: _____
City, State, Zip: _____
Employer Name: _____ Employer Number: () _____
Relationship to Patient: _____

Secondary Ins Name: _____ Co-Pay: _____
Insured Name: _____ D.O.B.: _____
Social Security #: _____ Home Phone: _____
Sex: Male / Female Mailing Address: _____
City: _____ State: _____ Zip: _____
Employer Name: _____ Employer Number: () _____

Other Information / Consent

Leave Messages: Home Yes / No Work Yes / No
Email Address: _____
*Pharmacy Name: _____ *Location: _____

*Initials _____ *I am either the patient or the legal guardian or representative of the patient. "I", "my" in this document refer to me as the patient or legal guardian or representative of the patient. I hereby authorize the assignment of benefits (payments) directly to Cool Springs Family Medicine for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

*Initials _____ *I have received a copy of the HIPAA Notice of Privacy Practices.

SIGNATURE OF RESPONSIBLE PARTY:

Date: _____