***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:______________