NEW PATIENT INFORMATION SHEET

It is very important that you complete the entire form, sign and date.

DATE: ____________________

PATIENT INFORMATION:

Last Name:____First: _____________________________________MI:_________________
Street Address: ____Mailing Address:____
City: ____ State: ________________ Zip Code:________________________
Social Security Number: _________ / __________ / __________ Date of Birth:__________ / __________ / __________
Home Phone: (______) ____Work Phone: (______) _________________________________

Employer: ____ Occupation: ___________________________________
Employer's Address: ____

Marital Status: ____________________ Spouse's Name: ____
Spouse's Social Security # ________ / ________ / ________ Spouse's Date of Birth: ________ / ________ / ________
Spouse's Employer:____________________________________ Spouse's Employer Phone: (______) ______________________________
Spouse's Employer's Address: ____

Emergency Contact Person: ____ Relationship: _________________________________
Phone Number: (______) ____Address: ____
May we call and leave you a message on your answering machine: _______Yes ______No With your spouse: ______Yes ______No

Are you currently a student? _____ Full Time _____ Part Time
Name and Address of School:____
Parent's Name: ____
Parent's Address: ____

How did you hear about CMC? __ Physician Referral __ News Paper __ Radio __Billboard
__ Friend Referral __ Insurance Plan __ Other ___________________________________

INSURANCE INFORMATION:

Primary Insurance Carrier: ____
Address: ____
Subscriber's Name: ____ Effective Date: ____
Policy or ID #: ____ Group #: ____
Primary Care Physician: _______________________________________ Effective Date: ____
Referring Doctor: ____

Secondary Insurance Carrier:____
Address: ____
Subscriber's Name: ____ Effective Date: ____
Policy or ID #: ____ Group #: ____
Primary Care Physician: _______________________________________ Effective Date: ____
Referring Doctor: ____

I hereby authorize direct payment of surgical/medical benefits to Cookeville Medical Center, P.C. for the services rendered to ______________________________. I understand that I am financially responsible for any balance not covered by my insurance, as allowed by law or by my insurance plan. I understand that if I have no insurance coverage, payment is due in full at time of service. Further, I agree that if it is necessary to refer this account to an agency, attorney or court for collection, I will pay all costs related to such collection action. I authorize Cookeville Medical Center, P.C., and its physicians to release any medical or incidental information and to request medical records from any health source that may be necessary for either medical care, or in processing medical claims. I understand that employees of Cookeville Medical Center access my medical chart for treatment, payment and operations of the clinic.

____ ___________________________________

(Patient/Parent/Guardian Signature) **(Date)**