

PATIENT INFORMATION (PLEASE PRINT)

Dr. DeLoach/ Dr. Hayes/ Dr. Bevans III/ Dr. Shaw/Dr. Bradney/Dr. Vander Schilden (Please circle which doctor you are seeing)

Patient's Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ SS# _____

E-mail address _____

Sex _____ Race _____ Ethnicity _____ Marital Status _____ Referring Physician _____

Employer _____ Phone _____ Ext _____

Employer Address _____ City _____ State _____ Zip _____

Spouse's Name (or Parent's name if Minor) _____ SS# _____

Spouse's/ Parent's Employer _____ Phone _____ Ext _____

Next of Kin, Not in the same household _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone _____

Have you ever been seen by any of our doctors? If yes, which doctor? _____
Please state when and where: _____

ARE YOU BEING SEEN FOR A WORK RELATED INJURY? YES NO DATE OF INJURY: _____
WAS YOUR EMPLOYER NOTIFIED? YES NO

Primary Care Physician _____

** PRIMARY INSURANCE _____

Address _____ City _____ State _____ Zip _____

Subscriber Name _____ Date of Birth _____

ID # _____ / Group# _____

** SECONDARY INSURANCE _____

Address _____ City _____ State _____ Zip _____

Subscriber Name _____ Date of Birth _____

ID # _____ / Group# _____

I authorize release of any medical information necessary to process all insurance claims. I understand and acknowledge primary responsibility for the medical fees not covered by insurance. I hereby authorize payment directly to the above named physician of the group insurance benefits otherwise payable to me. I also authorize release of medical records from North Metro Medical, Baptist Health, St. Vincent, North River Surgery and Springhill Surgery Center.(Signatures of patient if minor, parent or guardian please sign.)

Signed: _____ Date _____

Medicare Authorization Only

I request that payment of authorize Medicare benefits be made either to me or on my behalf to Drs. Stair, DeLoach, Hayes, Bevans III or Shaw for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ Date _____