TENNESSEE VALLEY SURGERY GROUP, P.C.
PATIENT INFORMATION

LAST NAME:________________________FIRST NAME:_________________________MIDDLE NAME:________________

ADDRESS:____CITY:_________________STATE:________ZIP CODE:__________

HOME PHONE:_________________CELL: __________________EMAIL:________________________

OK TO LEAVE A MESSAGE? **TEXT** YES ( ) NO ( ) **VOICEMAIL** YES ( ) NO ( ) **EMAIL** YES ( ) NO ( )

SOCIAL SECURITY #______________ ________DOB:__________________ SEX: FEMALE ( ) MALE ( )

SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOW ( ) RACE: WHITE ( ) BLK ( ) HISP ( ) OTHER ( )

PREFERRED PHARMACY:_________________ _____________ADDRESS :____________________ ____________

REFERRING DOCTOR: ________________________ PRIMARY DOCTOR:__________________________

RESPONSIBLE PARTY NAME:_______________________ RELATION TO PT:______________ ____ PHONE #____________

INSURANCE INFO: CO-PAY AMOUNT? $______________

PRIMARY INSURANCE: _______________ POLICY HOLDER: ____________________________

POLICY # _______________________ GROUP # ____________ POLICY HOLDERS DOB: _______________

SECONDARY INSURANCE: __________________ POLICY HOLDER: _________________________

POLICY #_______________________ GROUP # __________ POLICY HOLDERS DOB: _______________

EMERGENCY CONTACT AND PERSON(S) WE MAY RELEASE INFORMATION TO:

NAME:_____________________________ RELATION:_____________________ PHONE:____________________

NAME:______________________ _______ RELATION:_____________________ PHONE:____________________

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments: However, the patient is responsible for ALL fees, including collection, agency, and attorney fees, regardless of insurance coverage. Payment is due when services are rendered, unless other arrangements have been made in advance with the office manager. Co-pays are due at the time of services. I authorize payment of medical benefits to Tennessee Valley Surgery Group, P.C... I authorize the release of any medical or financial information necessary to obtain payment on my behalf.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Tennessee Valley Surgery Group, P.C. to release all medical records and pertinent medical information to any insurer, government agencies providing benefits, or anyone liable for charges. I authorize the release of said information to my referring physician, and to other medical providers who are or may become involved in my treatment.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I may obtain a copy of the Notice of Privacy Practices upon my arrival.

SIGNATURE: ____ **DATE:** ____________________________