Tennessee Valley Surgery Group, P.C.
PATIENT INFORMATION

Last name _____ First Name _____ Middle Name _____

Address _____ City _____ State _____ Zip code _____

Home phone _____ Work Phone _____ Cell phone _____

Social Security # _____ Birthdate _____ Circle answer: Female Male Married Single Widowed Divorced

Employer _____ Employer phone _____

Employer address _____

If not employed, are you disabled? YES NO Do you require a wheelchair van or ambulance for transport? YES NO

Referring physician: _____ Family Physician: _____

Are you a hospice patient? YES NO If yes, name of hospice: _____

ARE YOU HERE AS THE RESULT OF AN ACCIDENT? YES NO EMAIL ADDRESS_____

PHARMACY AND PHONE_____

Responsible Party
Name_____Middle_____Last_____

Address_____

Home phone _____Work_____Cell_____

Relationship to patient _____ Social Security # _____ Date of birth _____

Employer _____ Employer phone _____

Employer address _____

INSURANCE INFORMATION **COPAY AMOUNT**_____

Primary insurance _____Policy#_____Group#_____

Subscriber's name _____ DOB _____

Secondary insurance _____ Policy#_____Group#_____

Subscriber's name _____ _____DOB _____

Other insurance _____ Policy#_____Group#_____

Subscriber's name _____ _____DOB _____

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 service. I authorize payment of medical benefits to Tennessee Valley Surgery Group, P.C... I also authorize the release of any medical or financial information necessary to obtain payment on my behalf.

Signature _____ **Date** _____