WEST TENNESSEE MEDICAL GROUP

Patient Information Sheet **Welcome to our Practice**

Please complete and sign: (attach copy of **insurance ID** card **{**and **drivers license** as required**}**)

PATIENT INFORMATION (Please print)

Social Security # _____ First Name_____ MI _____ Last Name _____

Home Phone _____Work Phone _____Ext.____ Cell_____ Email_____

Sex ☐ M ☐ F Date of Birth ___/___/_____ Age _____ Preferred form of communication: ☐ email ☐ phone ☐ direct mail

Address_____ Appt # _____ City _____ State_____ Zip _____

RESPONSIBLE PARTY INFORMATION (Please print)

If you are the responsible party, mark "self" and move down to "Insurance Information".

Patient's relationship to responsible party: ☐ Self ☐ Spouse ☐ Dependent

First Name _____ MI _____ Date of Birth _____/____/_____ Age _____

Last Name _____ SSN_____ Sex ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone_____ Employer _____

Title_____ Employer's Address _____ City _____

State____ Zip _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

INSURANCE INFORMATION (Please print)

Primary Insurance_____ Telephone number _____

Group / Policy Number_____ Subscriber / I.D. Number_____

Name of Card Holder_____ Card Holder Date of Birth_____

Effective Date _____ Deductible $_____ Co-Pay $_____

Secondary Insurance_____ Telephone number _____

Group / Policy Number_____ Subscriber / I.D. Number_____

Name of Card Holder_____ Card Holder Date of Birth_____

Effective Date _____ Deductible $_____ Co-Pay $_____

ADDITIONAL PATIENT DATA (Please print)

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Student Status ☐ Full-Time ☐ Part-Time

Employer _____ Work Phone _____

Employer's Address_____City _____ State_____ Zip _____

Mother's Maiden Name _____

Emergency Contact: Name _____ Relationship_____ Phone: _____

Primary Care Physician: _____ Address: _____ Phone: _____

Name of Pharmacy:_____ Address: _____

Phone:_____ Fax:_____

Language preference:_____ Race:_____

Referred by _____ Signature_____ Date_____

Revised 09/13