1616 West Main Street
Lebanon, TN 37087
(615) 449-0990

*(Please fill out completely)*

## PATIENT INFORMATION

Name: (First) ______________________(MI) ________ (Last) ______________________
Date of Birth ____________________ Age __________ Sex: ❑ M ❑ F Marital Status ❑ S ❑ M ❑ W ❑ D
Address (Street) ______________________
(City, State, ZIP) ______________________
Phone #: (_____) __________ Social Security #: ______________________ Driver License #: ______________
Work #: (_____) __________ Employer: ______________________
Employer's Address: ______________________
Accident/Injury? ❑ Yes ❑ No Date of Accident/Injury ____________ Place of Accident/Injury ______________
If Student, School Name ______________________ Full/Part Time ______________
Referring Physician: ____________________ City/State of Referring Physician ______________________
If not referred by a physician, how did you choose our practice? ______________________

## RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: ______________________ Relationship to Patient ______________
Address (Street) ______________________
(City, State, ZIP) ______________________
Phone #: (_____) __________ Social Security #: ______________________ Driver License #: ______________
Work #: (_____) __________ Employer: ______________________
Employer's Address: ______________________
Friend or Relative Not Living With You: ______________________ Phone #: (_____) __________

## INSURANCE INFORMATION

Medicare #: ______________________ Medicaid #: ______________________
Insurance Co: ______________________ Phone #: (_____) __________
Insurance Co. Address: ______________________
Group #: ______________________ Certificate or I.D. #: ______________________
Policy Holder's Name ______________________ Relationship to Patient ❑ Self ❑ Spouse ❑ Dependent
Policy Holder's Employer: ______________________ Phone #: (_____) __________
Employer's Address: ______________________
***Policy Holder's Social Security #:*** ____________________ Date of Birth: ______________ Sex: ❑ M ❑ F

**If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!**

## INSURANCE INFORMATION

Insurance Co: ______________________ Phone #: (_____) __________
Insurance Co. Address: ______________________
Group #: ______________________ Certificate or I.D. #: ______________________
Policy Holder's Name ______________________ Relationship to Patient ❑ Self ❑ Spouse ❑ Dependent
Policy Holder's Employer: ______________________ Phone #: (_____) __________
Employer's Address: ______________________
***Policy Holder's Social Security #:*** ____________________ Date of Birth: ______________ Sex: ❑ M ❑ F

**I, the undersigned, assign to Tennessee Orthopedics, PC, all payments made payable to me or on my behalf, including, but not limited to surgical, medical, liability, or any other for all Tennessee Orthopedic charges for services to me. In addition, I authorize the release of my medical information needed to determine these benefits. I instruct my attorney(s), if any, to honor this Assignment. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges, whether or not they are covered by insurance or any other party.**

**Patient's Signature** ______________________________ **Date** ______________
**Or Responsible Party, if Patient is a Minor**