Patient Registration Form

PHILLIPS MEDICAL GROUP, P.C.
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Talbott, TN 37877

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phillipsmedicalgroup.com

Patient Information: Acct# _____

Name _____ Preferred Name _____ Birthdate _____
First Middle Last

Address _____ Apt. #_____

City _____ State_____Zip_____

Home Phone _____ Cell or Other Phone _____

E-mail Address_____ Patient Social Security # _____

Sex: ☐ Male ☐ Female

Status ☐ Single ☐ Married ☐ Widowed ☐ Student ☐ Retired ☐ Employed – Occupation: _____ ☐ Unemployed ☐ Disabled

Patient's Employer _____ Employer Phone No._____

Employer Address _____

How did you hear about us? _____

Financial Responsibility – Complete this section with the name and information of the person who will sign this form. ***The person who signs this form accepts assignment as the Guarantor responsible for patient bill.****

Responsible Party Name _____ Birthdate _____
First Middle Last

Address _____
(If different from above)

Telephone # _____ Social Security # _____ Relationship _____

Employer _____ Employer Phone # _____

Employer Address _____

Emergency Contact Person _____ Emergency Contact Person _____

Phone No. _____ Phone No. _____

Insurance Information

Medicare Patients: Is Medicare Primary ☐ Y ☐ N

Primary Insurance	Secondary Insurance
Insurance Co _____	Insurance Co _____
Name of Subscriber _____	Name of Subscriber _____
Birthdate of Subscriber _____	Birthdate of Subscriber _____
Social Security Number of Subscriber _____	Social Security Number of Subscriber _____
Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber ID Number: _____	Subscriber ID Number: _____
Group Number: _____	Group Number: _____

Advance Directive for Healthcare

I understand my right to execute a Living Will and/or Durable Power of Attorney for healthcare to assist in healthcare decisions if I become unable to make decisions.

I have a Living Will.	☐ Yes	☐ No
If "yes," copy provided for chart?	☐ Yes	☐ No
I have granted Durable Power of Attorney.	☐ Yes	☐ No
If "yes," copy provided for chart.	☐ Yes	☐ No

I herby authorize Phillips Medical Group, P.C. to disclose any information necessary for the processing of my claims related to my treatment at Phillips Medical Group, P.C. I understand that this authorization extends to the treatment and furnishing a copy of all reports related to my treatment. The question of privacy between Phillips Medical Group, P.C., my treating physician and myself are waived with regards to the information contained in the records and reports furnished to my insurance carrier. I understand my insurance carrier may not cover and/or pay for services rendered, and I agree to be financially responsible for any services that are not covered by my insurance carrier.

*Responsible Party Signature: _____ Relationship to Patient:_____ Date: _____