

Patient Registration Form

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Patient Information:

Acct# _____

Name _____ Preferred Name _____ Birthdate _____
First Middle Last

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell or Other Phone _____

Patient Social Security # _____ E-mail Address _____

Sex: Male Female Mother's Social Security # If Patient Newborn to 1 year old _____

Patient's School _____ Patient's Employer _____

School Address _____ Employer Address _____

School Phone No. _____ Employer Phone No. _____

Father's Name _____ Employer _____ Employer Phone _____

Mother's Name _____ Employer _____ Employer Phone _____

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 _____

Telephone # _____ Social Security # _____ Relationship _____
(If different from above)

Employer _____ Employer Phone # _____

Employer Address _____

Emergency Contact:

Emergency Contact Person _____ Emergency Contact Person _____

Phone No. _____ Phone No. _____

Insurance Information:

Primary Insurance

Insurance Co _____

Name of Subscriber _____

Birthdate of Subscriber _____

Social Security Number of Subscriber _____

Patient Relationship to Insured : Self Spouse

Child Other

Subscriber ID Number: _____

Group Number: _____

Secondary Insurance

Insurance Co _____

Name of Subscriber _____

Birthdate of Subscriber _____

Social Security Number of Subscriber _____

Patient Relationship to Insured: Self Spouse

Child Other

Subscriber ID Number: _____

Group Number: _____

I hereby 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: _____