PATIENT REGISTRATION FORM (Rev 06/17)

Please provide your insurance card and picture ID to the receptionist

Today's date:	Other Id: (*paper chart*)

PATIENT DEMOGRAPHIC INFORMATION

Last Name:	First:	Middle:	Preferred Name:
Maiden Name:	Prefix: (circle One) **Miss Mr. Mrs. Ms.**		Suffix: (circle One) **N/A I II III IV Jr. Sr.**

Date of Birth:	Age:	Gender Identity:	Race:
Social Security #: - -		Ethnicity:	Religion:

Relationship Status: (circle one)

Single Married Separated Divorced Widowed Domestic Partnership Living Together Common Law Other

Drivers License State:	Drivers License Number:	Primary Language:

Street address:	City:	State:	ZIP Code:

Home Phone:( )	Work Phone: ( )	Mobile: ( )	Which number is best?
Messages okay?	Messages okay?	Messages okay?	Home Work Cell
Fax: ( )	Pager: ( )	E-mail:	

Pharmacy Name: **Pharmacy Phone Number:**

EMPLOYER/SCHOOL INFORMATION

Employer/School:	Status:(circle one) **FT PT FT Student PT Student Unemployed**	Occupation/Position:
Phone or Ext. ( )	Hire Date: Termination Date (if applicable)	

ASSOCIATED PARTY INFORMATION

Emergency Contact:	Date of Birth :	Relationship to Patient:

Street Address:	City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	Mobile: ( )	

PARENT/GUARDIAN INFORMATION

* Please fill out below if patient is a minor* *We will need mother's SSN if patient is a newborn*

Parent/Guardian Name:	Date of Birth:	Relationship to Patient:

Street Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Mobile:	

INSURANCE INFORMATION

Please understand that you are financially responsible for all charges whether or not paid by insurance.

Primary Insurance:		**Secondary Insurance:**	
Member ID:	Group Number:	Member ID:	Group Number:
Plan Name and/or Number:		Plan Name and/or Number:	
Name of Policy Holder:		Name of Policy Holder:	
Relationship to Patient: ❒ Self ❒ Spouse ❒Other		Relationship to Patient: ❒ Self ❒ Spouse ❒ Other	
If other, please describe: _____		If other, please describe: _____	

POLICY HOLDER INFORMATION

INSURANCE NAME:

Holder Name (If different from above) Social Security Number Date of Birth

Street Address City State Zip Code

Employer Occupation

Primary Phone Cell Phone Work Phone

If you have additional insurance coverage, (private/commercial), other than the TennCare Plans (OmniCare, TLC or TennCare Select), you must report this coverage immediately for proper billing of your medical care. Failure to disclose information about private/commercial insurance while receiving TennCare benefits is considered TennCare fraud and is against the law.

Determination of fraud could lead to the following:

1. Loss of TennCare benefits and possible loss of commercial insurance coverage
2. Legal proceedings by the TennCare Bureau and this office to recover the cost of uncovered medical expenses and associated costs.
3. Termination of care by this office.

Patient, Parent or Guardian:_____ Relationship: _____ Date: _____

GUARDIAN / MINOR (17 AND UNDER) CONSENT

A. Patient is a minor and is _____ years of age.

- Name of Mother: _____
- Name of Father: _____

B. Patient is unable to consent because _____.

Parent or Guardian:_____ Relationship: _____ Date: _____

Witness to Signature: _____

SIGNATURE SECTION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my child/ward has a change in health, insurance or contact information.

Patient, Parent or Guardian:_____ Relationship: _____ Date: _____

CONSENT TO TREATMENT

I voluntarily consent to medical care at CMPM encompassing routine diagnostic examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physician's assistants, medical assistants, or their designees as is necessary in the medical staff's judgment. This consent is valid and remains in effect as long as I receive medical care at CMPM

Patient, Parent or Guardian:_____ Relationship: _____ Date: _____

If the patient is a minor or unable to consent please complete the following:

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize this office to release information regarding my protected health information to include account status, test results, and scheduled appointments and information regarding my health care to the persons listed below. Any person not listed will not be able to obtain any information whatsoever. (You do not need to list other physicians or insurance companies)

__Name: _____ Relationship to Patient:_____

__Name: _____ Relationship to Patient:_____

__Name: _____ Relationship to Patient:_____

__Name: _____ Relationship to Patient:_____

__Name: _____ Relationship to Patient:_____

__Name: _____ Relationship to Patient:_____

Patient, Parent of Guardian Signature: _____ Relationship:_____ Date :_____

PRIVACY STATEMENT

We consider any information that concerns your health, health care or payment for that care to be confidential and protected information. This notice describes our privacy practices, specifically how we use and disclose your medical information and what rights you have with respect to this information. This information includes your name, address, and other identifying data, and information on your health or the health services that have been or may be furnished to you. We require all of our employees, staff, volunteers and independent contractors to comply with these privacy practices. We are required by federal law to obtain an acknowledgment from you that you received this notice.

Patient, Parent or Guardian:_____ Relationship: _____ Date: _____

BENEFIT AUTHORIZATION

(a) I authorize CMPM to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care.

(b) I also request that payments of authorized benefits be made to me or on my behalf to CMPM for services rendered.

(c) I further authorize the release of medical information about treatment here to my doctor or anyone designated by me.

(d) I authorize the use of my signature on all insurance submissions.

(e) I understand I am responsible for payment of all medical expenses incurred due to services rendered.

(f) I agree to provide complete and accurate information about all insurance policies that I participate in and advise the doctor and staff of changes.

Patient, Parent or Guardian:_____ Relationship: _____ Date: _____

AUTHORIZATION TO LEAVE MESSAGES

I authorize CMPM to leave messages regarding pending appointments/or tests at the numbers indicated below. Please check all that apply:

❒ Home Phone ❒ Mobile Phone ❒ Work Phone

Patient, Parent or Guardian:_____ Relationship: _____ Date: _____

PHOTO AUTHORIZATION

I authorize CMPM to use my photo as part of my protected health record for identification and treatment purposes only.

Patient, Parent or Guardian:_____ Relationship: _____ Date: _____

NO SHOW/ CANCELLATION POLICY

Please call 24 hours in advance to cancel or reschedule your appointment. If you do not call, you will be considered a "No Show" and will be charged a $20 fee. Your insurance will not cover this therefore you will be responsible for payment.

Patient, Parent or Guardian Signature: _____Relationship: _____ Date: _____