

Crockett Medical Clinic, Inc.

New Patient Registration Form

Please complete this form in FULL.

Today's Date: _____

Full Name: _____ Gender: _____

Social Security No.: _____ Marital Status: _____ Date of Birth: _____

Race (circle one): White African American Asian Other Race: _____

Ethnic Group (circle): Hispanic Non-Hispanic Other: _____ Preferred Language: English Spanish _____

Preferred Contact / Reminder Method (circle one): Phone Cell Phone Mail

Who is responsible for this account? Name: _____ Date of Birth: _____ Gender: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

REQUIRED Under 18: Mother's Name _____ Father's Name _____

Name of Spouse/ Parent: _____ Social Security Number: _____

Spouse/ Parent Date of Birth: _____ Home Ph: (____) _____ Cell: (____) _____

Spouse/ Parent Mailing Address: _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ Phone: (____) _____

Is the patient covered by Insurance? (Circle one): Yes No

We will not accept insurance information past 60 days of date of service.

Primary Insurance: _____

Policy Holder/Relationship: _____/_____ Date of Birth: _____

Secondary Insurance: _____/_____

Policy Holder/Relationship: _____/_____ Date of Birth: _____

I have read the Notice of Privacy Practices for Crockett Medical Clinic: Copy available to me.

I have read Crockett Medical Clinic's Nondiscrimination policy. Copy available to me.

* Signature (Patient or Responsible Party): _____

TENNCARE FRAUD STATEMENT (If Applicable)- Crockett Medical Clinic is required to file any medical insurance coverage prior to filing a claim with TennCare. With my signature, I agree that I have provided all medical insurance coverage. I understand it is considered TennCare Fraud not to report ALL (primary) insurance coverage.

**Signed (Patient or Responsible Party): _____ Date: _____

I agree and authorize medical attention to include but not limited to: Treat, Diagnose, prescribe for any physical ailment, physical injury or deformity; prescribe, administer any drug or medication as deemed necessary by a healthcare provider of Crockett Medical Clinic, Inc. I consent to allow medication reconciliation with my prescription insurance history and/or my other medical providers. I hereby authorize Crockett Medical Clinic, Inc. to furnish information concerning my treatment to insurance companies as deemed necessary, and I hereby irrevocably assign to Crockett Medical Clinic, Inc. all insurance benefits payable to me by my insurance company, not to exceed the charges shown. I understand that I am financially responsible for any amounts that are not covered by my insurance and this authorization, Crockett Medical Clinic, Inc. cannot accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim. I understand that I am responsible for my account. The undersigned further agrees that in the event his/her account is turned over to an attorney, the undersigned shall be responsible for all costs of collection, including out-of-pocket expenses, court costs, and attorney fees.

I request payment of authorized Medicare benefits be made to Crockett Medical Clinic, Inc. for any services furnished to me by said clinic. I authorize any holder of my medical information authority to release any information needed to determine these benefits payable for related services to the Health Care Financing Administration and its agents.

*Signed (Patient or Responsible Party): _____ Date: _____ Relationship: _____