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):** _____

Advanced Directives/ Living Will: **Yes** I have one) Please provide a copy to the clinic **No** (I do not have one)

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 to and authorize medical treatment as deemed necessary by 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 irrevocable 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**_____