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: _____ **Language (circle):** English Spanish Other: _____

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

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

Mailing Address: _____ **City:** _____ **State:** ___ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Emergency Contact (Next of Kin): _____ **Ph:**(___) _____**Relationship:**_____

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 been given/ offered the Notice of Privacy Practices for Crockett Medical Clinic:

*** 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***_____