



CONFIDENTIAL PATIENT REGISTRATION

Copies of your insurance cards must be presented and will be copied and verified.
A copy of your driver's license is required.

PATIENT INFORMATION

Name: _____ Social Security #: _____ Race: _____
Address 1: _____ Home Phone #: _____
Address 2: _____ Cell Phone: _____ Date of Birth: _____
City, State, Zip: _____ Age: _____
Referring MD: _____ Primary Care MD: _____
Marital Status: [] Married [] Single [] Widowed E-Mail: _____

PATIENT EMPLOYMENT

Employer Name: _____ Phone: _____

SPOUSE'S INFORMATION

Name: _____ Social Security #: _____ Date of Birth: _____
Employer Name: _____

EMERGENCY CONTACT(S)

Name: _____ Phone: _____
Name: _____ Phone: _____

How did you hear about us?

___ Family ___ Friend ___ Church ___ Word of Mouth ___ Yellow Pages Ad ___ MD Referral ___ Other

Would you like information regarding a living will or Power of Attorney? ___ Yes ___ No

Patient Authorization

Regardless of your insurance coverage, you as the patient, are always responsible for the payment of your charges. A surgical and/or obstetrical deposit may be required if necessary. Our office requires that all co-pays be paid prior to being seen by the provider unless you have Medicare or an insurance our office is contracted with. Office charges are to be paid by cash, check or credit card at the time of service. Counselors are available to discuss large dollar charges and payment schedules.

Authorization & Assignment:

I authorize WCG to release any information acquired by my physician/or staff to my insurance carrier(s). I authorize payments directly to my physician. I recognized and accept responsibility for any balance or fees not covered by insurance. I agree to pay the balance in a prompt manner. In any event this account is referred to an outside agency, credit reporting bureau or attorney for collection, I agree to pay all attorney fees, collection costs, court costs and/or any other expenses incurred in its collection, according to the 1989 statutes of the State of Tennessee.

Patient or Responsible Person's Signature: _____ Date: _____

