

FAMILY HEALTH GROUP, INC.

WELCOME

Thank you for selecting our healthcare team! Our goal is to provide you with the best possible care. To help us meet your healthcare needs, please fill out this form **completely in ink**. We will be glad to assist you in any way possible. Please ask us!

**PERSONAL
INFORMATION**

Name: _____
 By what name do you wish to be called: _____
 Street Address: _____
 City: _____ ST: _____ ZIP: _____
 Home Phone # _____ Mobile # _____
 Work Phone # _____ Ext: _____
 Employer: _____ Occupation: _____

**EMERGENCY
CONTACT**

Name: _____ Relationship: _____
 Home Phone: _____ Work Phone: _____

Patient Social Security #: _____ Patient Birthdate: _____
 Male Female Patient Marital Status: _____

**INSURANCE
INFORMATION
PRIMARY**

Primary Insurance Name: _____ **Policy #:** _____
Group #: _____ **(Please provide insurance card for us to copy)**
 Name of Insured: _____
 Relationship to patient: _____
 Insured's birthday: _____ SSN: _____
 Employer: _____
 Date employed: _____ Is Insurance through Employer? Yes No

**INSURANCE
INFORMATION
SECONDARY**

Additional Insurance Name: _____ **Policy #:** _____
Group #: _____ **(Please provide insurance card for us to copy)**
 Name of Insured: _____
 Relationship to patient: _____
 Insured's birthday: _____ SSN: _____
 Employer: _____
 Date employed; _____ Is Insurance through Employer? Yes No

**TENNCARE
MEDICAID**

Have you applied for or do you have TennCare or Medicaid coverage (State Program):
 Yes No

**FAMILY HEALTH GROUP, INC.
WELCOME (CONTINUED)**

**TELEPHONE
PERMISSION**

Where do you prefer to receive calls:

- Home Phone # _____ Mobile # _____
 Work Phone # _____ Ext: _____

Messages:

I _____ agree to allow _____ M.D.,/or a
(Print Name) (Physician's Name)
 member of their staff to leave a message (please check all that are acceptable).

- On my answering machine.
 With _____ (specify name and relationship).
 Exclusively with me.

Regarding:

- An appointment. Referrals
 Pending test results. RX Information
 Billing Information Other _____

This document will be considered valid unless a written revocation is received.

**FINANCIAL
ARRANGEMENTS**

For your convenience, we offer the following methods of payment. Please check which option you prefer.

- Cash Personal Check Credit Card (Visa/MasterCard)

The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Family Health Group. Co-pay in full is expected at the time of service. No exceptions. Any other necessary financial arrangements must be made prior to service..

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Family Health Group to release to any insurance companies and/or other intermediaries and/or carriers of any medical or other information needed for claims reimbursement.

I hereby assign, transfer, and set over to Family Health Group all of my rights, title and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies.

I hereby acknowledge and accept responsibility for payment in full for all of services rendered to me by Family Health Group.

_____/_____/_____
Date

Signature of Patient/Guardian

Thank you for filing out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.

FOR OFFICE USE ONLY:

HIPAA Privacy Policy: Has the patient acknowledged receipt of Family Health Group's Privacy Policy? Yes

Advanced Directives: Advanced Directives Executed ? Yes No

New Patient Information

Updated Information Date Updated _____ Date Updated _____ Date Updated _____