

# TENNESSEE PLASTIC SURGERY

## Patient Information

Acct. # \_\_\_\_\_

Date Completed: \_\_\_\_\_

Referred By: \_\_\_\_\_

Primary M.D. \_\_\_\_\_

**Please print and complete all blanks.**

### PATIENT INFORMATION

Name: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: (If available) (\_\_\_\_\_) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's Phone No.: (\_\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Employer's Phone No.:(\_\_\_\_\_) \_\_\_\_\_

In Case of Emergency Contact (someone outside your household) Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone No.:(\_\_\_\_\_) \_\_\_\_\_

### PERSON RESPONSIBLE FOR PAYMENT: COMPLETE THIS SECTION ONLY IF DIFFERENT THAN ABOVE

Name: \_\_\_\_\_ Home Phone No.:(\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer's Name and Address: \_\_\_\_\_

Employer's Phone No.: \_\_\_\_\_ Occupation: \_\_\_\_\_

### COMPLETE IF WORKMEN'S COMPENSATION & ATTACH REQUIRED APPROVAL LETTER

Employer: \_\_\_\_\_ Phone No.:(\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Workmen's Compensation Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone No.:(\_\_\_\_\_) \_\_\_\_\_ Claim No.: \_\_\_\_\_

### INSURANCE INFORMATION

1. Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Policy No.: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Group No.: \_\_\_\_\_

Phone No.:(\_\_\_\_\_) \_\_\_\_\_

Name of Person Policy is Issued To: \_\_\_\_\_

Group Name or Policyholder \_\_\_\_\_

2. Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Policy No.: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Group No.: \_\_\_\_\_

Phone No.:(\_\_\_\_\_) \_\_\_\_\_

Name of Person Policy Is Issued To: \_\_\_\_\_

Group Name or Policyholder: \_\_\_\_\_

3. TN Care No.: \_\_\_\_\_ Eligibility Dates: \_\_\_\_\_

4. Medicare No. \_\_\_\_\_ Eligibility Dates: \_\_\_\_\_

I authorize the release of any medical information necessary to process insurance claims. I further authorize payment of medical benefits to Tennessee Plastic Surgery in the event they file insurance claim.