Healthplus

Phone: 423-634-4242

A Physician Treating People, Not Just Symptoms

PATIENT INFORMATION **Today's Date:**_____

Legal First Name:_____ Legal Last Name:_____

Middle Name:_____ Name you prefer to go by:_____

Date of Birth:_____ Sex: (please check one) ◯ Male ◯ Female

Mailing Address:_____

City:_____State:_____Zip Code:_____

Primary Phone: (____)_____(please check) ◯ Home ◯ Cell ◯ Work

Secondary Phone: (____)_____(please check) ◯ Home ◯ Cell ◯ Work

SS#_____ Email address:_____

Marital Status: ◯ S ◯ M ◯ D ◯ W Spouse Full Legal Name:_____

Employer:_____ Employer Phone:_____

Emergency Contact (someone not living in your household)

Contact Name:_____Relationship:_____

Primary Phone:_____ Secondary Phone:_____

Person responsible for bill if patient is a minor:_____

Date of Birth:_____ Phone:_____

Address (if different) _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Name_____SS#_____DOB_____

Relation to primary cardholder_____

Secondary Insurance Company:_____

Name_____SS#_____DOB_____

Relation to primary cardholder_____

Financial Responsibility Agreement:

Patient must provide accurate and up to date insurance information to ensure proper filing; otherwise the bill will become the patient's responsibility. Our office will file insurance for all reimbursable services however our policy requires that you pay fees due today, including copayments, deductibles and fees not covered by your insurance plan. I authorize the release of medical or other information about me to the above listed service provider in order to process my claim. I authorize any collection or attorney fee owed in addition to court costs if charges are not paid in full.

Date:_____Signature:_____