PATIENT INFORMATION

LAST NAME FIRST NAME MIDDLE (MAIDEN)

ADDRESS CITY STATE ZIP CODE

AREA CODE-PHONE NO. BUSINESS PHONE BIRTHDATE

SEX MARITAL STATUS SOCIAL SECURITY NO.

EMPLOYER ADDRESS

SPOUSE'S EMPLOYER ADDRESS PHONE

FAMILY INFORMATION

FATHER__________ BIRTHDATE__________ SS#__________

MOTHER__________ BIRTHDATE__________ SS#__________

SPOUSE__________ BIRTHDATE__________ SS#__________

CHILDREN'S NAME AND BIRTHDATE (If applicable)

MESSAGE PHONE # - OTHER THAN YOUR OWN (MUST HAVE FOR EMERGENCIES)

NAME RELATIONSHIP PHONE

WORKMAN'S COMPENSATION _____YES ______ NO

COMPANY NAME PHONE VERIFIED BY

PERSONAL INSURANCE (PCN, BC, ETC) POLICY NUMBER

1.__________ __________

2.__________ __________

3.__________ __________

MEDICARE __________

HEALTH NET TENNCARE __________

ACESS MED PLUS TENNCARE __________

BLUE CROSS TENNCARE __________

PHOENIX TENNCARE __________

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DEXCRIBED BELOW. I AGREE TO ASSUME THE COST OF MY BILL AND ALL COLLECTION EFFORTS. I AUTHORIZE DR. ALAN DRAKE OR HIS PHYSICIAN EXTENDER TO PROVIDE TREATMENT.

PARENT/GUARDIAN SIGNATURE: __________ DATE__________