PATIENT REGISTRATION

Date	For Internal Use Only	Patient Number

PATIENT INFORMATION

Social Security # | Date of Birth
First Name | Middle | Last Name
Home Address | City | State | Zip
Email Address | Race _______ | Ethnicity ______________

Gender (Circle as many as are appropriate)

Birth Sex: Male Female Transgender Other
Current Sex: Male Female Transgender Other

Marital Status (Circle One): Married Single Divorced Widowed
Home Phone ( )
Cell Phone ( )

(Circle One) Employed Retired Disabled F/T Student Other
Work Phone ( )

Employer | Referring Physician

How did you hear of us?

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance | ID # | GR #
Name of Insured | DOB | SS#

SECONDARY INSURANCE INFORMATION

Insurance | ID# | GR #
Name of the Insured | DOB | SS#

EMERGENCY CONTACT

Relationship
First Name | Middle | Last
Home Phone ( ) | Work Phone ( ) | Cell ( )

SPOUSE/GUARANTOR/RESPONSIBLE PARTY

Social Security # | Sex | Date Of Birth
Relationship | Daytime Phone ( )
First Name | Middle | Last Name
Address | City | State | Zip
Employer | Address
City | State | Zip

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent if Minor) | DATE

UNIVERSITY MEDICAL GROUP

Patient Privacy Questionnaire and Notification

Patient Name:____ Date of Birth:___________________

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

Contact Information:

I would prefer to be contacted at*: _______Home #___________________________________

_______Cell #____________________________________

_______Work #___________________________________

_______Other #___________________________________

______May ONLY leave information with me. (If you check here, no other choice should be marked).

______May leave appointment reminders on my answering machine/voicemail.

______May leave lab results on my answering machine/voicemail.

______May leave general questions/information on my answering machine/voicemail.

______May leave a message with a call back number only.

Please list the name of the individual and relationship of anyone we may give information to:

Name:____________________________________Relationship:_______________________

Name:____________________________________Relationship:_______________________

______May leave appointment reminders with the above listed person

______May leave lab results with the above listed person

______May leave general questions/information with the above listed person

______May discuss billing information with the above listed person

______I prefer that all healthcare messages be given to the above listed person

*If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney's fee allowed by Tennessee Law.

Signature of Patient____ Date____________________