Account # ________________

PCP ______________________

Patient Information Sheet

(18 years & over)

Patient Name ____ Sex: ________
First Middle Last

Address ____
Street/POB City/State Zip code

Date of Birth ________/________/_______________ Social Security ________-________-_______________

Home Phone ________-________-_______________ Cell Phone ________-________-_______________

Employer ____________________________________ Work Phone ________-________-_______________

Email address ____________________________________ Do you reside ___ alone ___ w/parents ___ school

In case of Emergency who should we contact?

Name ____ Home Phone ______-______-_____________

Relationship ____ Cell Phone ______-______-_____________

Insurance Information: Please present insurance card.

Primary Insurance ________________________ Subscriber Name ______________________________________

Relationship to patient ____________________ Cell Phone __________________ Employer________________

Subscriber Date of Birth ___________________________ Subscriber Soc. Sec ______-______-_____________

Secondary Insurance ___________________ Subscriber Name ____

Relationship to patient ___________________ Cell Phone __________________ Employer ________________

Subscriber Date of Birth ___________________________ Subscriber Soc. Sec ______-______-_____________

I, the undersigned, give my consent to treat. I authorize payment of medical benefits to the physician or supplier for services rendered. I authorize the release of any medical information necessary to process insurance claims and certify the information contained herein is correct. I understand that Highland Pediatrics may not be contracted with all insurance plans. I will be responsible for any amount not paid by insurance.

I understand that Highland Pediatric physicians are not TennCare or Medicaid providers, therefore, Highland Pediatrics cannot file TennCare or Medicaid. I will be responsible for all charges incurred while covered by TennCare or Medicaid.

I agree to pay collection fees if legal action is necessary in the collection effort of this account.

Signature ____ Date ____________________________

(Please See Reverse Side)

COMMUNICATIONS CONSENT:

By providing my cell, land-line, or any other number(s), I expressly consent to receiving communications from the Provider, its staff, its contractors, collection agents, and other, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, prerecorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers are not a condition of receiving healthcare services.

Accept ☐

Decline ☐

____ _______________

Signature of Parent, Legal Representative, or Legal Guardian *Date*

PHOTO CONSENT:

By checking a response below, I consent to allowing Highland Pediatric posting pictures/photos of myself in the office that I have mailed or given to the physicians or staff.

Accept ☐

Decline ☐

____ _______________

Signature of Parent, Legal Representative, or Legal Guardian *Date*