CARE MEMPHIS CLINIC, PLLC

PATIENT INFORMATION				❑ *New Patient* ❑ *Established PT*
Patient's FIRST Name: MIDDLE: LAST:				Social Security #:
Birth date: / /	Sex: ❑ M ❑ F	Marital status (circle one) Single / Married / Partner	Employment Status (circle one) Employed / Retired / Student / Unemployed / Disabled	Employer Name:
Your Address:	City		State:	Zip Code:
Race: ❑Decline ❑White ❑American Indian /Alaska Nat. ❑Asian ❑Black/African American ❑Nat.Hawaii/Oth Pac Islander ❑Other		Ethnic Group: ❑Non-Hispanic ❑Hispanic/Latino ❑Decline		Language: ❑English ❑Spanish ❑Other:_________
Primary Phone#: ❑ Cell ❑ Work ❑Home ( )	Alternate Phone#: ❑ Cell ❑ Work ❑Home ( )		Email Address: Appointment reminder by email? ❑ Yes ❑ No	
Referring Physician Name:	How did you hear about our office?			
Pharmacy:	Reason for visit:		Date of Inj/Onset:	

RESPONSIBLE PARTY:

<u>Person Financially Responsible</u> ❑ Self Only→Skip to insurance section ❑ Other Guarantor→Complete this section	Guarantor's Full Name:	Patient's Relationship to Guarantor: ❑ Child ❑ Spouse ❑ Other:
Address (if different):	Birth date: / /	Social Security #:

INSURANCE INFORMATION:

<u>Primary</u> Insurance Company Name:	Plan Name:	Type of Plan: ❑ PPO ❑ POS ❑ HMO ❑ Medicaid ❑ Medicare ❑Tricare ❑ Medicare HMO ❑ WC ❑ Lien
Claims Address:		Phone#: ( )
Policy#:	Group #:	Group Name:
<u>Secondary</u> Insurance Company Name:	Plan Name:	Type of Plan: ❑ Medicare Supplemental ❑ Medicaid ❑ Other Employer/Commercial ❑ Spouse's Plan (Pls. complete guarantor section) ❑ Other:
Claims Address:		Phone#: ( )
Policy#:	Group #:	Group Name:
Rx Plan Name:	Rx Plan Member ID:	Rx Plan Phone Number:

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to Care Memphis Clinic, PLLC as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

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Patient Signature **Date**