NORTHSIDE MEDICAL PROFESSIONALS, PC
WELCOME

Thank you for selecting our healthcare team! Our goal is to provide you with the best possible care. To help us meet your healthcare needs, please fill out this form **completely in ink**. We will be glad to assist you in any way possible. Please ask us!

PERSONAL INFORMATION

Name: _____ Name you wish to be called: _____
Mailing Address: _____ Physical Address: _____
City: _____ State: _____ Zip: _____
Home Phone # _____ Cell Phone # _____ Work Phone # _____
Employer: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home: _____ Work: _____ Cell: _____

Patient Social Security #: _____ Patient Birthdate: _____
☐ Male ☐ Female Marital Status: _____ Email: _____
Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Other _____

INSURANCE INFORMATION PRIMARY

Primary Insurance Name: _____ Policy #: _____ Group #: _____
Name of Insured: _____ Relationship to Patient: _____
Insured's Birthday: _____ SSN: _____
Address if Different than Patient: _____

INSURANCE INFORMATION SECONDARY

Secondary Insurance Name: _____ Policy #: _____ Group #: _____
Name of Insured: _____ Relationship to Patient: _____
Insured's Birthday: _____ SSN: _____
Address if Different than Patient: _____

TENNCARE MEDICAID

Have you applied for or do you have TennCare or Medicaid coverage (State Program):
☐ YES ☐ NO

TELEPHONE PERMISSION

Where do you prefer to receive calls:
☐ Home Phone # _____ ☐ Cell Phone # _____ ☐ Work Phone # _____

Messages:

I _____ (Print Name) agree to allow _____ (Physician's Name), MD/ or a member of their staff to leave a message (please check all that apply):

☐ On my answering machine.
☐ With _____ (specify name and relationship).
☐ Exclusively with me.

Regarding:

☐ An appointment ☐ Referrals
☐ Pending test results ☐ RX Information
☐ Billing Information ☐ Other _____

This document will be considered valid unless a written revocation is received.

The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Northside Medical Professionals, PC. Co-pay in full is expected at the time of service. No exceptions. Any other necessary financial arrangements must be made prior to service.

AUTHORIZATION, ASSIGNMENT AND REPSONSIBILITY OF ACCOUNT

- I hereby authorize Northside Medical Professionals, PC to release to any insurance company and/or other intermediaries and/or carriers of any medical or other information needed for claims reimbursement.
- I hereby assign, transfer and set over to Northside Medical Professionals, PC all of my rights, title and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies.
- I hereby acknowledge and accept responsibility for payment in full for any and all services rendered to me by Northside Medical Professionals, PC.
- Non-payment of accounts will result in referral to an outside collection agency that could impact the patient's credit record. Legal fees and collection costs incurred to collect outstanding accounts will be the patient's responsibility.
- I hereby acknowledge Northside Medical Professionals, PC may perform a Pharmacy Check if warranted.
- I hereby acknowledge receipt of the Notice of Privacy Practices given to me by Northside Medical Professionals, PC.

_____ Signature of Patient/Guardian

_____ Date