ARTHRITIS ASSOCIATES, PLLC
1035 EXECUTIVE DRIVE
HIXSON, TN 37343
PH: (423) 826-0800 FAX: (423) 826-0810

REVISED 7/2015

PATIENT INFORMATION **DATE: _____**

_____

LAST NAME **FIRST NAME** **MIDDLE NAME**

_____

PREVIOUS LAST NAME (MAIDEN, ETC, IF APPLICABLE) NICKNAME OR NAME YOU PREFERRED TO BE CALLED BY

SOCIAL SECURITY #:_____BIRTHDATE:_____ SEX : ( ) Male ( ) Female

ADDRESS:

_____

Street and House or Apt #

_____

City **State** **Zip**

Race **Primary Language** **Ethnicity**

☐ White ☐ Alaskan Native ☐ English ☐ Hispanic/Latino
☐ Black/African American ☐ American Indian ☐ Spanish ☐ Not Hispanic/Latino
☐ Multiracial ☐ Asian ☐ Other ☐ Unknown or not reported
☐ Other (list) ☐ Indian (list) _____
_____
☐ Unknown/Not Reported

CONTACT INFORMATION: **PLEASE MARK (X) BY PREFERRED METHOD OF CONTACT**
DAYTIME PHONE NUMBER REQUIRED **DAYTIME PHONE**: _____ ☐ OK TO LEAVE MESSAGE
☐ DO NOT LEAVE MESSAGE

HOME PHONE: _____ ☐ OK TO LEAVE MESSAGE ☐ DO NOT LEAVE MESSAGE ____ PREFERRED

CELL PHONE: _____ ☐ OK TO LEAVE MESSAGE ☐ DO NOT LEAVE MESSAGE ____ PREFERRED

WORK PHONE: _____ ☐ OK TO LEAVE MESSAGE ☐ DO NOT LEAVE MESSAGE ____ PREFERRED

E-Mail:_____ _____ PREFERRED (must be registered on patient portal)

MARITAL STATUS ( ) Single ( ) Married ( ) Widowed ( ) Child ( ) Other _____

STUDENT STATUS Full-time ☐ Yes ☐ No

PRIMARY CARE PROVIDER: _____PH:_____

ADDRESS: _____
Street City State Zip

PATIENT EMPLOYMENT

EMPLOYER:_____ ☐ Active ☐ Retired ☐ Disabled ☐ Unemployed

OCCUPATION: _____ Date If Retired or Disabled: _____

ADDRESS_____PH:_____
Street State Zip

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SPOUSE OR PARENT (IF PATIENT IS A MINOR) INFORMATION

SPOUSE NAME (OR PARENT IF PATIENT IS A MINOR**)** _____

SOCIAL SECURITY **#:**_____BIRTHDATE**:**_____

ADDRESS (IF DIFFERENT THAN PATIENT**):**_____

_____

EMPLOYER NAME: _____PH:_____

EMPLOYER ADDRESS:_____
Street City Zip

EMERGENCY CONTACT

NAME: _____

RELATIONSHIP: _____**CONTACT NUMBER:** _____

ADDRESS: _____
Street City State Zip

RESPONSIBLE PARTY

IF PATIENT IS UNDER 18, A RESPONSIBLE PARTY MUST BE PRESENT WITH THE PATIENT AT ALL TIMES.

RESPONSIBLE PARTY IF OTHER THAN PATIENT: _____

BILLING ADDRESS: _____
Street City State Zip

PHONE: _____**RELATIONSHIP TO PATIENT**_____
(i.e. parent, Power of Attorney, Legal Guardian)

AUTHORIZATION

I authorize treatment of the person named above and agree to pay all fees for such treatment. I authorize release of any information necessary for the processing of insurance claims. I authorize any insurance payments to be released either to me or on my behalf to Arthritis Associates, PLLC for services provided. In the event any legal action should become necessary to collect an unpaid past due balance, I agree to pay reasonable attorney fees or other costs as the Court determines proper.

_____Date:_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PRINTED NAME OF RESPONSIBLE PARTY_____

_____
RELATIONSHIP OF RESPONSIBLE PARTY (i.e. parent, Power of Attorney, Legal Guardian)

PLEASE PRESENT YOUR INSURANCE CARDS AND PICTURE ID TO RECEPTIONIST

In order to fully comply with regulations concerning with identity theft prevention policies, we do require patients to bring the following documents at the time of their appointment: Driver's license or other photo ID, current Health Insurance ID card (parent or guardian should bring this information if patient is a minor). You will also be asked to verify your health Insurance Information and demographic information at each subsequent visit and to update this form on an annual basis. Thank you.

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NOTICE AND DISCLAIMERS

ACCIDENT CLAIMS
If condition is related to accident, please give date and description of accident:

_____

_____

_____

Arthritis Associates, PLLC does not accept Workman Comp or Auto Accident Claims and by this notice, I acknowledge I am responsible for all charges incurred at the time of service regardless of any pending or future accident claims.

_____**Date:**_____
Signature of Patient or Responsible Party

MEDICARE ADVANTAGE PLANS
Arthritis Associates, PLLC does not accept any Medicare Advantage plans and will not see patients with these plans in our office.

MEDICAID/TENNCARE
Arthritis Associates, PLLC does not accept Tenncare or any other state Medicaid plans.

OUT OF NETWORK INSURANCE PLANS
It is the responsibility of the patient to check to see if we are on your insurance network before coming to the office. If your insurance plan requires you to see a physician in your network and we are not on your network, we will not be able to see you without prior approval by your insurance company and our office. Any out of pocket costs are to be paid at the time of service. You may contact our insurance department if you have any questions about coverage before your appointment date.

_____ _____
Patient/Responsible Party Signature **Date**

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PHARMACY AUTHORIZATION

Pharmacy: Our office uses an electronic prescribing program for prescriptions that are eligible for an electronic prescription. Please list the preferred pharmacy you would like to use. All prescriptions will be sent to this pharmacy unless you specifically request another pharmacy. By signing below, you are also authorizing your doctor to access and view your medication history as available from any electronic data base (such as SureScripts, etc.) that our office is required to utilize in order to process the electronic prescription program.

PREFERRED LOCAL PHARMACY NAME:

_____ PH: _____

ADDRESS: _____FAX:_____

PREFERRED MAIL-ORDER PHARMACY NAME:

_____ PH:_____

ADDRESS: _____ FAX :_____

_____ DATE: _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY