University Women's Services

New / Update #

J. Michael Breen, MD | Stacy Boyd, MD | Michael Smith, MD

PATIENT INFORMATION

Name: (LAST) (FIRST) (MI)

Permanent Address

City State Zip

Mailing Address

City State Zip

Please Circle: Employed Student Retired

Please Circle: Male Female

Employer

Address

City State Zip

Date of Birth Age

Home Phone ( )

Social Security #

Work Phone ( )

Please Circle: Single Married Divorced Separated Widow

Cell Phone ( )

SPOUSE / PARENT OR LEGAL GUARDIAN INFORMATION (complete section that applies only)

Spouse:

Name

Address

City State Zip

Social Security #

Date of Birth

Phone: (HOME) ( ) (WORK) ( )

Employer

Responsible Parent:

Name

Address

City State Zip

Social Security #

Date of Birth

Phone: (HOME) ( ) (WORK) ( )

Employer

PRIMARY PHYSICIAN - REFERRAL PHYSICIAN

Referring Physician **Phone ( )**

DISCLOSURE OF PROTECTED HEALTH INFORMATION

According to office policy, test results or release of medical information will be provided to the patient only. Please specify below whom information may be released to other than yourself. Please complete the information below and sign your name to verify your permission.

Please Circle all that apply:

Myself Only Son / Daughter Husband / Wife Other (state Name & relation)

May we leave messages at your? Please Circle all that apply:

Home Answering Machine Cell Phone Work Voice Mail Other (please specify)

I have received a copy of University Women's Services Privacy Notice explaining the uses and disclosure of my health information:

Please Circle one: **Yes** **No**

Patient or Legal Guardian Signature Date

PLEASE COMPLETE BACK OF FORM

PLEASE PRESENT YOUR CURRENT INSURANCE CARD(S) TO OUR FRONT DESK SO THAT WE MAY MAKE COPIES AND FILE YOUR CLAIMS. IF YOU DO NOT HAVE YOUR INSURANCE CARD WE WILL NOT BE ABLE TO SUBMIT A CLAIM TO YOUR INSURANCE FOR SERVICES.

IT IS THE PATIENT'S RESPONSIBILITY TO PROVIDE ACCURATE AND TIMELY INSURANCE INFORMATION.

INSURANCE INFORMATION

PRIMARY Insurance

Name of Insurance : _____

Claims Mailing Add. _____ City _____ State _____ Zip _____

ID / Policy Number _____ **Group Number** _____

Name of Insured _____ **Relation to Patient** _____

Insured Address _____ City _____ State _____ Zip _____

Date of Birth _____ **Social Security #** _____

Home Phone ( ) _____ **Work Phone** ( ) _____

Insured Employer _____

SECONDARY Insurance

Name of Insurance : _____

Claims Mailing Add. _____ City _____ State _____ Zip _____

ID / Policy Number _____ **Group Number** _____

Name of Insured _____ **Relation to Patient** _____

Insured Address _____ City _____ State _____ Zip _____

Date of Birth _____ **Social Security #** _____

Home Phone ( ) _____ **Work Phone** ( ) _____

Insured Employer _____

IN CASE OF EMERGENCY CONTACT: _____ **Phone Number** ( ) _____

How did you hear of our services? _____

ADVANCED DIRECTIVES

It is the right of every adult citizen in Tennessee (18 years and over) to sign a Living Will, as well as a Durable Power of Attorney for Healthcare that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure your provider has a copy for your file.

AUTHORIZATION

authorize University Women's Services to release to any insurance company, managed care organization, state agency(ies), federal agency(ies), centers for Medicare & Medicaid services, Third Party Administrators, and/or Workers Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize University Women's Services to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to University Women's Services to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities. I request that payment of Medicare, MediGap, Medicaid, Managed Care Organization, Third Party Administrators, Commercial insurance, Worker's Compensation, Liability, and/or any other insurance benefits be made on my behalf to University Women's Services. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment of benefits apply.

Patient or Legal Guardian Signature _____ **Date** _____