Rocky Top Medical Center, PC
Patient Information Sheet
Please Print Information

Date: ____/____/_____ Email:_____ Cell #:_____ Home #:_____

Patient: Last:_____ First:_____ Middle:_____ Sex: M: F:

Street: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Age: _____ Birthday: ____/____/_____ Marital Status: _____

Do you have a Living Will? _____ Do you have a Power of Attorney?:_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? (list): _____

Patient Employer (if child: mother's name and employer): _____

Occupation: _____ Phone:_____

Spouse's Name (if child: father's name and employer): _____

Occupation: _____ Phone: _____

If patient is a minor, who is responsible for this account?: _____ Relationship to patient:_____

Father's Social Security #: _____ Mother's Social Security #: _____

Name of Primary Insurance: _____ Insured Name: _____

Insured Social Security #: _____ Insured Date of Birth: ____/____/_____

Name of Secondary Insurance (if any): _____ Phone: _____

In case of Emergency, who should be notified? _____ Phone: _____

How did you learn about our practice: _____ Former Physician: _____

Assignment and Release

I. The undersigned have insurance coverage with _____ (your insurance company). And assign directly to ROCKY TOP MEDICAL, PC all medical benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the doctor to release all information necessary to assure the payment of benefits. I authorize the use of this insurance submission.

Signature of Insured Guardian: _____ Date: ____/____/_____

Medicare Authorization

I request the payment of authorized Medicare benefits be made either to me on my behalf of ROCKY TOP MEDICAL CENTER, PC for any services furnished me by that organization. I authorize any holder of medical information about me to release to HCFA and its agents any information necessary to pay the claims. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer of the agency shown. In Medicare assigned cases, the organizations agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date: ____/____/_____