TAMMY E. BAKER, MD

OBSTETRICS  *GYNECOLOGY*

CONFIDENTIAL PATIENT REGISTRATION AND AUTHORIZATION

ALL INFORMATION IS IMPORTANT FOR MEDICAL REVIEW, HOSPITAL ADMISSION AND FOR INSURANCE FILING. THIS DATA MUST BE COMPLETED PRIOR TO BEING SEEN BY THE PHYSICIAN.

Copies of your insurance card(s) and drivers license are required. Champus or Tenncare are not accepted by this practice as either primary or secondary insurance. All plans that cover you must be presented today, as we do not go back and bill a secondary insurance at al later time.
How did you hear about our office? Family:____ Friend:____ Physician:____ Insurance company:____

Regardless of your insurance coverage you – as the patient – are always responsible for the payment of your charges at time of visit unless you have Medicare or an HMO, PPO. Office charges are to be paid by check or cash.

PATIENT'S NAME: _____ Date: _____

Street address: _____

City, State, and Zip Code: _____

Circle one: Married Divorced Widowed Single Separated

Patient's social security number: _____ Birth date:_____ Age:_____

Patient's home phone:_____ Cell phone:_____ Work phone:_____
Where would you like us to contact you regarding visits, abnormal labs, prescriptions? Please initial:
_____**HOME** _____**CELL** _____**WORK**

What is your preferred Pharmacy? _____ Phone Number:_____

Patient's employer's name & address: _____
_____Type of work:_____

Husband's name:_____ Work phone:_____
Husband's employer's name:_____
Husband's social security number:_____ Husband's birth date:_____

Emergency contact (other than above):
Name:_____ Phone:_____
Address:_____

Primary Care Physician:_____Phone:_____Address:_____

Authorization & Assignment: I authorize Dr. Tammy Baker to release any information acquired by my physician/or staff to my insurance carrier. I authorize payments directly to my physician. I recognize and accept responsibility for any balance or fees not covered by insurance, and agree to pay the balance in a prompt manner. In any event this account is referred to an outside agency, credit bureau or attorney for collection, I agree to pay all attorneys fees, collection costs, court costs and/or any other expenses incurred in its collection according to the 1989 statues of the State of Tennessee.

Patient's Signature: _____ Date:_____

Responsible Party's signature and social security (if not patient):_____
(i.e. minor)

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