Martin Medical Center, P.C.
117 Kennedy Drive
Martin, TN 38237

Date: _____

Chart #: _____

Patient Information:

Patient Name: _____ Date of Birth: _____
First Middle Last
Married __ Widowed __
Address: _____ Divorced __ Single ___
City: _____ State: _____ Zip Code: _____
SS#: _____ Cell Phone #: _____
Employer: _____ Home Phone #: _____
Employer Address: _____ Work Phone #: _____
Permission to leave message: Yes or No

Spouse / Parent Name: (*circle Spouse or Parent if patient is a child*)

Name: _____ Cell Phone #: _____
First Middle Last
Home Phone#: _____
SS#: _____ Work Phone #: _____
DOB: _____
Employer: _____

Insurer's Information: *(Please make sure to present your insurance card to the receptionist)*

Name: _____ Date of Birth: _____
First Middle Last
Address: _____
SS#: _____ Home Phone#: _____
Employer: _____ Work Phone #: _____
Employer Address: _____ Cell Phone #: _____

Emergency Contact: (Relative or Friend not living with you):

Name: _____ Relation to you: _____
Home Phone #: _____ Cell Phone # _____ Work Phone #: _____
Address: _____

Living Will:

For patients over the age of 18:
Do you have an advanced directive (Living Will) ? ___ Yes ___ No
Would you like a packet about living wills? ___ Yes ___ No

Consent To Treat/Insurance Authorization:

I hereby authorize examination and/or treatment by the Physicians and/or Allied Health Professionals of Martin Medical Center. I authorize the release of any medical information needed to process insurance claims. I authorize Martin Medical Center, PC to act as my agent to help determine and obtain benefits from my insurance company. I understand that I am completely responsible for all charges incurred. I do hereby certify that the above information is complete and accurate. I acknowledge that I have read the Notice of Privacy Practices.

_____ _____
Signature Date

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