

Martin Medical Center. PC
117 Kennedy Drive
Martin, Tennessee 38237

Date: _____

Chart #: _____

Patient Information:

Patient Name: _____

Address (No P.O. Boxes): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ SS#: _____ Birth Date: _____

Can we contact you by e-mail? e-mail Address: _____

Patient Employer: _____ Work Phone #: _____

Responsible Party if other than patient (Spouse/Parent name) (do **not** list insurance information here):

Name: _____ SS#: _____
Last First Middle

Address: _____ Home Phone: _____

Employer: _____ Employer Address: _____

Work Phone: _____ Birth Date: _____

Emergency Contact (Not living with you): Name: _____

Phone #: _____ Address: _____

Work Phone #: _____ Relationship to you: _____

Living Will

For patients over 18:

Do you have an advance directive (Living Will)? _____ Yes _____ No

Would you like a packet about living wills (advance directives)? _____ Yes _____ No

Consent To Treatment Statement:

I hereby authorize examination and/or treatment by the Physicians and/or Allied Health Professionals of Martin Medical Center.

Signature

Date

Insurance Authorization:

I hereby request that payment of authorized insurance, Medicare or Medigap be made to my physician for any services furnished me by that physician. I authorize Martin Medical Center, PC to act as my agent to help determine and obtain benefits from my insurance company, Medicare or Medigap insurer. I authorize any holder of medical information about me to release to my insurance company, Medicare or Medigap insurer any information needed to determine these benefits. I agree to pay all collection expenses incurred in connection with this account.

Signature

Date

Witness Signature

Date