PINNACLE MEDICAL GROUP

345 23rd Ave North Suite 306
Nashville, TN 37203
Ph: 615-320-3999 Fax: 615-320-8877

Name _____ SS# _____-_____-_____
First Middle Initial Last

Gender: ☐ Female ☐ Male Date of Birth _____/_____/_____ Primary Language: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Ethnicity: _____ Race: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home: (_____) _____ -_____ Cell: (_____) _____ -_____

E-Mail: _____ ☐ Consent to text messages

## PHARMACY INFORMATION

Name & Address: _____ Phone: (_____) _____ -_____

Mail Order: _____ Fax: (_____) _____ -_____

## INSURANCE INFORMATION

Primary: _____ Insured Party: ☐ Self ☐ Spouse ☐ Parent

Secondary: _____ Insured Party: ☐ Self ☐ Spouse ☐ Parent

If you do not have insurance and are being seen as a self-pay patient check here: ☐

## PLEASE PROVIDE INFORMATION FOR AN EMERGENCY CONTACT

Name: _____

Relationship: _____ Phone: (_____) _____ -_____

Do you have an advanced directive (living will, POA)? If yes, please provide a copy. Yes ☐ No ☐

I agree to be financially responsible for services not covered by my insurance company and financially responsible for any fees associated with collections and/or litigation.

I understand that it is my responsibility to give accurate and updated demographic information to my health care provider (address, phone numbers, insurance, etc.). If I give inaccurate insurance information, I will be responsible to pay the claim in full and no claims will be filed to insurance after 90 days from the date of service. All balance statements will be sent to your patient portal.

Signature _____ Date _____/_____/_____