Updated 02/24/2015

Pinnacle Medical Group
Patient Information Form
Please Print

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

Gender: Female___ Male___ Date of Birth_____ Marital Status (circle): Married Single Divorced Widowed Other

Address: _____ City: _____ State: ____ Zip Code: _____

E-Mail _____ Home Phone:_____ Cell Phone: _____

Race:_____ Primary Language:_____

PHARMACY INFORMATION:

Name & Street Address:_____ Telephone #: (_____)_____-_____

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

INSURANCE INFORMATION:

Primary_____ Insured Party: Self ___ Spouse ___ Parent ___

Secondary_____ Insured Party: Self ___ Spouse ___ Parent ___

Other Coverage _____ Insured Party: Self ___ Spouse ___ Parent ___

PLEASE COMPLETE THE FOLLOWING INFORMATION IF YOU ARE INSURSED THROUGH A SPOUSE OR PARENT.

Name _____ Relationship _____ Date of Birth _____

SS# _____ Home Phone: _____ Cell Phone: _____

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

How did you hear about our practice? _____

EMERGENCY CONTACT

Name of closest relative or friend:_____ Relationship: _____ Phone: _____

I **authorize** any other health care provider whom I have seen in a clinic, hospital or other facility to send medical information to Pinnacle Medical Group at: 345 23rd Ave N, Suite 306, Nashville, TN 37203. Tele: (615) 320-3999 Fax :(615) 320-8877.
I **authorize** any holder of my medical information to release to CMS and its agents or my insurance company any information necessary to determine benefits payable for related medical services.

I **authorize** Pinnacle Medical Group to view my prescription history from external sources.

I **agree** to be financially responsible for services not covered by my insurance company. I also agree to be financially responsible for any fees associated with collections and/or litigation. I understand that it is my responsibility to give accurate demographic information to my health care provider and keep those records updated as that information changes (i.e. change of address, change of phone numbers, change of insurance information, etc.)

There will be a **$50.00 "no show"** charge for all appointments missed (or not rescheduled **two business day in advance**). I understand this charge is my responsibility to pay and it will not be filed to my insurance company.

Signature of Patient or Representative _____ Date_____