

Campbell Clinic

901-759-3100

1400 S. Germantown Road

Germantown, TN 38138

Please Print	Patient Registration	Please Print
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Last Name _____ Emergency Contact Name _____

First Name _____ Emergency Contact Relation _____

Middle Initial _____ Emergency Contact Phone _____

Sex _____ Employer Name _____

Previous Last Name _____

RESPONSIBLE PARTY INFORMATION

DOB _____ Patient's Relationship to Resp. Party _____

SSN _____ Resp. Party Last Name _____

Address _____ Resp. Party First Name _____

Address Line 2 _____ Resp. Party Middle Initial _____

Zip _____ Resp. Party DOB _____

City _____ Resp. Party Address _____

State _____ Resp. Party Address Line 2 _____

Home Phone _____ Resp. Party Zip _____

Work Phone _____ Resp. Party City _____

Mobile Phone _____ Resp. Party State _____

Email _____ Resp. Party SSN _____

Doctor seeing today _____ Resp. Party Phone _____

Marital Status _____ Resp. Party Employer _____

Primary Care Physician _____

Other Insurance Information

Referring Physician _____ Other Insurance Co. _____

Primary Insurance Information Other Policy Holder _____

Primary Insurance Co. _____ Other Policy Holder Address _____

Policy Holder _____ Other Policy Holder SSN _____

Policy Holder SSN _____ Other Policy Holder DOB _____

Policy Holder DOB _____ Other Policy Holder Sex _____

Policy Holder Sex _____ Other Policy Holder City _____

Policy Holder City _____ Other Policy Holder State _____

Policy Holder State _____ Other Policy Holder Zip _____

Policy Holder Zip _____

How did you hear about us? _____

Are you a High School athlete that was injured in a school sanctioned sporting event? YES ___ NO ___

If yes, what school: _____

I hereby authorize (a) payment of insurance benefits otherwise due to me to be made directly to Campbell Clinic, (b) release of information including protected health information to insurance companies as needed to file for payment for services incurred, (c) Campbell Clinic to obtain records from other sources as may be necessary in the diagnosis or treatment, and (d) understand that I am financially responsible for payment to Campbell Clinic for charges related to services provided or incurred by me or my dependents.

Signature (Responsible Party) _____ Date _____