



THIS FORM MUST BE COMPLETED IN FULL
PATIENT INFORMATION

PLEASE PRINT

Patient Name (Last, First, MI) _____		Age _____	Marital Status M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>	
Address _____		City / State _____	Zip _____	
Home Phone _____	DOB ____ / ____ / ____	Sex: M / F	SOC. SEC. # _____ - _____ - _____	
Occupation _____		Employer Name _____		
Address _____		City _____	St _____	Zip _____ Phone _____ Ext _____
Name of Spouse or Parent _____		DOB ____ / ____ / ____	SS# _____	
Address _____		City _____	St _____	Zip _____ Phone _____ Ext _____
Email address if known: _____		Referred by: <input type="checkbox"/> Friend <input type="checkbox"/> MD <input type="checkbox"/> Phone Book <input type="checkbox"/> Other		

RESPONSIBLE PARTY / GUARANTOR

Responsible Party's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Responsible Party's Date of Birth ____ / ____ / ____
Responsible Party's Name (Last, First, MI) _____	
Address _____ City _____ State _____ Zip _____	
Home Phone _____	Work Phone _____ SS# _____
Employer _____ Address _____	
Responsible Party's Spouse's Name _____ DOB ____ / ____ / ____ Work Phone _____	

INSURANCE INFORMATION

Insurance Company _____	I.D. Number _____	Group # _____
Relationship to Cardholder Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> _____	Cardholder's DOB ____ / ____ / ____	
Cardholder's Name _____		Cardholder's Address _____
City _____	St _____	Zip _____ Cardholder's Home Phone _____
Cardholder's Employer _____	Cardholder's Work Phone _____	SS# _____
What hospital are you required to use? _____		

PERSON TO CONTACT IN CASE OF EMERGENCY - MUST COMPLETE THIS SECTION

Name _____	Phone _____
Address _____	Relationship _____

I understand that OLIVE BRANCH FAMILY MEDICAL CENTER is not a provider for MS Medicaid or TennCare. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including all private insurance and other health plans to OBFMC. This assignment will remain in effect until revoke by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize assignee to release all information to secure payment. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay interest on any past due monthly account balance. Should my account be placed with a collection agency or referred to an attorney for purposes of seeking judicial relief, I agree to pay all costs of collection, reasonable attorney's fees, expenses, all costs of court, plus pre and post-judgment interest on any judgment. **PAYMENT IS DUE AT TIME OF SERVICE.**

SIGNATURE OF PATIENT/GUARDIAN

DATE