CAROLINE H. CHESTER, M.D.

2201 MURPHY AVENUE SUITE 403 NASHVILLE, TENNESSEE 37203 (615) 320-3773

(Please Print)

Patient Name_____
Last First Middle

Birth Date_____/_____/_____ Social Security #_____ Gender_____

Address_____

City_____ State_____ Zip_____

Home Phone (_____) _____ Cell Phone (_____) _____

We will attempt to contact you via all phone numbers provided unless you tell us otherwise.

E-Mail Address_____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

Reason for Visit_____

Please list all individuals we may speak with regarding confidential information and phone numbers where we may leave confidential messages:_____

_____

How were you referred to our office? ____ Physician ____ Friend/Relative ____ Internet ____Advertisement

Employer Name_____ Occupation_____

Employer Address_____ City/State/Zip_____

Work Phone (_____)_____ Ext._____

Primary Care Physician_____ Phone Number (_____) _____

Address_____ City/State/Zip_____

Referring Physician *(if different from Primary Care Physician)*_____

Address_____ City/State/Zip_____

Phone Number (_____)_____

Primary Insurance *(Please complete this section in full. Additionally, we will make a copy of your insurance card.)*

Patient's Insurance Company_____

Name of Policy Holder_____ Relationship to Patient_____

Birth Date _____/_____/_____ Social Security Number_____

Employer_____ Employer Phone Number (_____) _____

Secondary Insurance *(if applicable)*

Patient's Insurance Company_____

Name of Policy Holder_____ Relationship to Patient_____

Birth Date _____/_____/_____ Social Security Number_____

Employer_____ Employer Phone Number (_____) _____

(continued on reverse side)

Spouse Information *(if applicable)*

Name _____
Last First Middle

Cell Phone (_____)_____ Work Phone (_____) _____

Employer_____

Employer Address_____ City/State/Zip_____

Parent Information *(Please complete this section only if patient is covered under a parent's insurance.)*

Father's Name_____
Last First Middle

Address *(if different from patient)*_____

City_____ State_____ Zip_____

Home Phone (_____) _____ Cell Phone (_____) _____

Employer_____ Employer Phone Number (_____) _____

Employer Address_____ City/State/Zip_____

Mother's Name_____
Last First Middle

Address *(if different from patient)*_____

City_____ State_____ Zip_____

Home Phone (_____) _____ Cell Phone (_____) _____

Employer_____ Employer Phone Number (_____) _____

Employer Address_____ City/State/Zip_____

Emergency Contact *(other than household)*

Name_____ Relationship to Patient_____

Home Phone (_____)_____ Cell Phone (_____) _____

Race/Ethnicity *(please circle one)* White Black Hispanic Latino American Indian Hawaiian Native Other

Preferred Language_____

Financial Agreement and Authorization for Treatment

The above information is true to the best of my knowledge. I authorize treatment of the person named above and agree to pay for all charges for such treatment. As a courtesy to you, this office will prepare and file any insurance claim which I have in connection with treatment received, and I agree, as evidence of my signature, to assign payment of any applicable benefits payable to my insurance company to this office. A copy of this agreement will be considered as valid as the original. I understand the practice is not responsible for any and all amounts which insurance does not pay, including any deductible amounts, coinsurance or charges not covered. I understand and agree that if it becomes necessary to refer this account to an attorney or a collection agency for collection of payment I will be responsible to pay all reasonable collection agency and/or attorney fees and court costs.

I have received a copy of my Patient Bill of Rights (available at front desk).

_____ _____
Patient Signature Date