CAROLINE H. CHESTER, M.D.

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

Patients Under 18 Years of Age ***(please print)***

Patient Name_____
Last First Middle

Birth Date____/____/____ Social Security #_____ Gender_____

Address_____

City_____ State_____ Zip_____

Home Phone (_____) _____ E-Mail Address_____

Mother's Name_____ Mother's Cell Number (_____)_____

Father's Name_____ Father's Cell Number (_____)_____

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

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

_____

Reason for Visit_____

How were you referred to our office? ___ Physician ___ Friend/Relative ___ Internet ___ Advertisement

Primary Care Physician_____ Phone Number (_____) _____

Address_____

City_____ State_____ Zip_____

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

Address_____ Phone Number (_____)_____

City_____ State_____ Zip_____

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

Primary Insurance

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)

Father's Name _____
Last First Middle

Address *(if different from patient)* _____

City _____ State _____ Zip _____

Home Phone *(if different from patient)* (_____) _____

Employer _____ Employer Phone Number (_____) _____

Employer Address _____

Mother's Name _____
Last First Middle

Address *(if different from patient)* _____

City _____ State _____ Zip _____

Home Phone *(if different from patient)* (_____) _____

Employer _____ Employer Phone Number (_____) _____

Employer Address _____

Legal Guardian(s) *(if applicable)* _____
Last First Middle

Address _____

City _____ State _____ Zip _____

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

Emergency Contact *(other than parents)*

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).

_____ _____
Signature of Parent or Legal Guardian Date