PATIENT REGISTRATION FORM

Patient Information

Last:	First:	Middle:
Social Security Number: / Date of Birth: / Sex: Male____ Female_____		Email Address: May we send informational emails to you? Yes____ No____
Home Phone: ___Preferred	Cell Phone: ____Preferred	Work Phone: ___ Preferred
Street Address:	City, State & Zip:	Ethnicity/Race *Optional* Preferred Language *Optional*
May we leave a message regarding your care (x-ray, lab results, etc.) on your preferred phone? ___ Yes ___ No	Employer and Address:	Occupation:

Primary Care Physician: Name, Address, Phone and Fax Number

Emergency Contact:

Name:	Phone:	Relationship:

Guarantor Information:

Last:	First:	Middle:
Social Security Number: / Date of Birth: / Sex: Male____ Female_____		Relationship:
Home Phone: ___Preferred	Cell Phone: ____Preferred	Work Phone: ___ Preferred
Street Address:	City, State & Zip:	Employer Information: Name, Address, Phone

Insurance Information

Primary Insurance	Insurance Plan Name:		
Subscriber Name:	Subscriber Date of Birth:	Relationship:	
Policy ID:	Group Number:		

Secondary Insurance	Insurance Plan Name:	
Subscriber Name:	Subscriber Date of Birth:	Relationship:
Policy ID:	Group Number:	

Reason for Today's Visit

Please specify the names of the people with whom we can discuss your medical care:

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

Authorization, Acknowledgment and Release for ALL Treatment at this Facility

Authorization for Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray and medication for myself and my dependents.

Assignment of Insurance Benefits: I authorize payment directly to Well-Key Health for all benefits and the release of information for all services and payments otherwise payable to me.

TennCare/Medicaid Programs: I acknowledge that Well-Key does not participate in any Tenn Care/Medicaid programs and claims will not be filed to any of these programs as primary or secondary insurance, I accept full financial responsibility.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party. I understand that I am to pay in full today for all services rendered unless my insurance is accepted. If my insurance is accepted, I must pay all applicable co-pays, percentages and remaining balances. If you are unable to verify if my insurance at the time of service, I will pay in full for all services. A $25 fee will be applied to your account if it has been placed with a collection agency for non-payment.

Release of Records: I authorize Well-Key Health to release (verbal or in-writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employer purposes, or other health care operations, quality management, utilization review, transfer or follow up purposes.

Receipt of Privacy Practices: I acknowledge that I have received & read the Well-Key Health Notice of Privacy Practices.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature:_____ Date:_____

Guaranator/Guardian Signature:_____ Date: _____