W. Stanford Blalock, M.D., PLC
Plastic and Reconstructive Surgery
279 Clear Sky Court, Suite B – Clarksville, TN. 37043
Phone: 931-906-9860 Fax: 931-906-9858

PATIENT PERSONAL INFORMATION- *(please print clearly)*

Last Name | First Name | M.I. | Date of Birth | Social Security#

Address | City | State | Zip | Home Phone ( ) | Cell Phone ( )

SPOUSE OR PARENTS- *(fill out only if patient is under 18 yrs of age)*

Relationship to patient _____

Last Name | First Name | M.I. | Date of Birth | Social Security#

Address | City | State | Zip | Home Phone ( ) | Cell Phone ( )

EMERGECY CONTACT- *(someone not listed above)*

Last Name | First Name | M.I. | Relationship to patient

Address | City | State | Zip | Home phone ( ) | Cell phone ( )

EMPLOYMENT INFORMATION *(please print clearly)*

Employer | Occupation | Work Phone ( )

INSURANCE INFORMATION *(It is the responsibility of the insured to determine if we are in network)*

Name of Primary Insurance Company | ID Number | Group Number

*Name of Insured Person | Date of Birth | Social Security# | Relationship to patient

Name of Secondary Insurance Company | ID Number | Group Number

*Name of Insured Person | Date of Birth | Social Security# | Relationship to patient

(continued on back)

X I request that any medical records needed for my evaluation and treatment of care be released to Dr. Blalock upon his request. I hereby authorize W. Stanford Blalock, M.D. to furnish my insurance company (ies), attorney, legal representative or appropriate parties including other physicians all information which said parties may request concerning my present illness or injury. I hereby assign to the doctors/facility all monies to which I am entitled for medical and/or surgical indebtedness to said physicians, surgeons and facility. It is understood that any money received from the above-named parties, over and above my indebtedness will be refunded when my bill is paid in full. I understand that I am financially responsible to said doctors for charges not covered by this assignment. Cosmetic procedures and deductibles are to be prepaid. We will collect co-payments at time of service. Patient agrees to pay all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies of no less than 35%. Such contingency fees to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. You agree, in order for us to service our account, we may contact you by wireless telephone numbers, e-mails or text messages and using any information you have provided. A photo copy of this authorization shall be considered as effective and valid as the original.

Print Name of person that completed this form Date

Signature of Patient (or parent/guardian if patient is under 18 years of age) Date

ACCIDENT INFORMATION

Date/Time of accident Location of accident Type of injury

Is there a lawsuit pending? YES NO

If yes, please list the name, address and phone number of the attorney handling the case.

Please provide a brief description of the accident and injury sustained:

WORK INJURY INFORMATION *(Complete this only if you are being seen for a work related injury)*

Was the injury reported to your employer? YES NO Date/Time reported _____

Name/Address of Employer at time of injury ( ) Phone number

Name/Address of Industrial Insurance Carrier (not individual Insurance)

Name of Case Worker File or WCAB Case Number Name of person who authorized services