W. STANFORD BLALOCK, MD, PLC

279 Clear Sky Court, Suite B - Clarksville, TN, 37043

Patient Information

M / F

Last Name | First Name | M.I. | Date of Birth | Age | Circle One

Address | City | State | Zip

(_____) Home Phone | (_____) Cell Phone | (_____) Work Phone

SS# _____ - _____ - _____ Email Address _____

Employer | Occupation | Employer Address | City | State | Zip

How did you hear about us? ☐ Yellow pages ☐ Seminar ☐ Internet ☐ Radio ☐ Newspaper ☐ Relative ☐ Other
☐ Physician -- Please give full name, address and /or clinic detail _____

Family Physician | Address or Clinic Name

Reason for Consultation

Spouse or Parent

Parent data needed if patient is under 18 years of age, I give my permission to have Dr. Blalock evaluate and/or treat _____
Parent or Guardian signature

Last Name | First Name | M.I. | Birth Date | Relationship to Patient

Mailing Address | City | State | Zip

SS# _____ - _____ - _____ (_____) Home Phone | (_____) Cell Phone

Employer | Occupation | Work Phone

Emergency Contact

In case of emergency contact: (someone not listed above)

Name: _____ Phone #:(_____)_____

Relationship to Patient _____ Alternative Phone # (_____)_____

Release of Medical Information and Assignment of Benefits

Cosmetic procedures are to be prepaid. We will collect co-payments at the time of services. I hereby authorize W.Stanford Blalock, M.D. to furnish my insurance company(ies) attorney, legal representatives or appropriate parties including other physicans, all information which said parties my request concerning my present illness or injury. I hereby assign to the doctor all monies to which I am entitled for medical or surgical indebtedness to said physican. It is understood that any money recieved 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 financialy responsible to said doctor for charges not covered by this assignment. I request that any medical records needed for my evaluation & treatment or care be released to Dr.Blalock upon his request. Patient agrees to pay all cost of collection including attorney fees, collection fees, and continent fees to collection agencies of not less than 35% such contingency fee 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, notify you of information pertaining to your account or medical condition, or for the purpose of collection, we may contact you by telephone at any number provided by you, including wireless telephone numbers. We may also contact you via e-mail or text message using any e-mail address you provide. Methods of contact may include the use of pre-recorded and artificial voice messages and/or use of an automated dialing device.

_____ _____
Signature of Patient (or parent if patient is under 18 yesrs of age) Date

_____
Name of person that completed this form

INSURANCE INFORMATION

Name and address of **PRIMARY** Insurance Company *(see below) Effective Date

Name of Insured Person | Date of Birth | Relation to Patient | ID# or Social Security # | Group #

NOTE: ***Secondary Insurances*** *- the following information is required by Primary Insurance Carriers*

Name and address of **SECONDARY** Carrier *(see below) Effective Date

Name of Insured Person | Date of Birth | Relation to Patient | ID# or Social Security # | Group #

***Please initial that you understand, we do / do not participate with your insurance or accept their fee schedule amount** (circle one) _____ (Initials)

ACCIDENT INFORMATION

Date if Injury | Place of Injury (at home, work, etc.) | Is a lawsuit pending? Yes/No (circle one)

If Yes, name and address of your attorney Phone#

Describe how accident happened:

WORK INJURY

(Complete this section **only** if you are being seen today for a work-related injury)

Did you report it to your employer? Yes/No When? _____ (Date) To Whom? _____ (Name and Title)

Name and Address of Employer **at time of accident** Phone #

Name and Address of Industrial Insurance Carrier (**not** group insurance company) Phone #

Name of Case Worker | File or WCAB Case # | Services authorized by (name)

EMERGENCY SERVICE

Name of Hospital Was surgery performed? Yes/No (circle one)

Emergency Room / Outpatient / Inpatient (circle one) Date Admitted _____ Date Discharged _____

DATE OF ADMISSION	STATUS ☐ 23 hr. hold ☐ Outpatient	IS YOUR CONDITION CAUSED BY AN ACCIDENT? ☐ Yes ☐ No	DATE/TIME OF ACCIDENT	DO YOU HAVE AN ADVANCED DIRECTIVE? ☐ Yes ☐ No

FAMILY PHYSICIAN	REFERRING PHYSICIAN	SURGEON

ALLERGIES	DIAGNOSIS