

PATIENT INFORMATION

Date: _____

Name: _____ SSN#: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

DOB: _____ Age: _____

Your Occupation: _____

Employer: _____ Work Phone: _____

Marital Status: Married Single Divorced Widow

Spouse's Name: _____ Spouse's SSN#: _____

Spouse's Employer: _____ Spouse's DOB: _____

Emergency Contact/Relationship: _____

Emergency Contact Phone (outside of home): _____

Referring Physician: _____

PLEASE ALLOW US TO COPY YOUR INSURANCE CARDS FOR OUR FILES

I request that payment of authorized Medicare or other insurance benefits for any services rendered to Dr. Maurice Rawlings be made to Maurice Rawlings Jr., MD, doing business as the Breast Center of Chattanooga. I authorize the release of medical information about me to the Health Care Financing Administration or to any other of my insurance companies as needed to determine benefits payable to related services. I understand that my signature requests that payment be made to the above provider and that I authorize release of information necessary to pay my claims. I also authorize release of my medical records to other medical providers as necessary for continued care.

Your Signature: _____ Today's Date: _____

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