

# CHATTANOOGA BONE & JOINT SURGEONS, P.C.

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W e l c o m e t o o u r p r a c t i c e !

## Patient Information

Patient's Name	Last	First	Middle	
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Birthdate	Social Security #
Address	Home Phone			
City, State, Zip	Work Phone			
Spouse's Name	Age	Birthdate	Social Security #	
Emergency Contact Person	Emergency Phone			
Who referred you to us?	How did you hear about our practice?			

## If The Patient Is A Minor

Father's Name	Mother's Name		
Address	Address		
City, State, Zip	City, State, Zip		
Social Security #	Social Security #		
Age	Birthdate	Age	Birthdate
Home Phone	Work Phone	Home Phone	Work Phone
Employer	Phone	Employer	Phone

## Employment Information

Patient's Employer's Name	Insurance Contact
Address	Phone
City, State, Zip	

## Financial Statement and Information

I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services or supplies rendered. I also understand that failure to agree to and sign this form will convert my account to a self-pay status requiring all of my charges to be paid in full at the time of service unless other arrangements have been made.

Primary Insurance Company	Patient/Guardian Signature agreeing to above
Secondary Insurance Company	

## Primary Care Provider Information

Who is your Primary Doctor?	Office Phone
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## Insurance Statement

### Authorization of Release of Medical Information and Assignment of Benefits

I hereby authorize the release of medical information to my insurance company and authorize payment directly to the physician for insurance claims understanding that the federal standards of private health information release are being followed by this practice (i.e. HIPPA). Further information can be obtained by requesting it from the receptionist or Privacy Officer.

Patient or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_