## PATIENT INFORMATION

Date____________________________

Name _________________________________________________________________ Social Security No. ______________________________

Street Address____________________________________________________City____________________State _______Zip Code __________

Home Phone _____________________ Cell Phone ______________________ E-Mail______________________________________________

Preferred Methods of Contact: ❑ Text Message ❑ E-Mail ❑ Phone Call (please choose preferred number) ❑ Home ❑ Cell ❑ Work

❑ Male ❑ Female Date of Birth____________________ Age_____ ❑ Single ❑ Married ❑ Widowed ❑ Other _____________

Race/Ethnicity: ❑ White/Caucasian ❑ Black or African American ❑ Asian ❑ Hispanic or Latino ❑ Other ____________________

Referred by: ❑ Internet Search ❑ Social Media ❑ Friend/Family Member _________________________ ❑ Other __________________

Reason for your Visit ____________________________________________________________________________________________

Patient Employer ____________________________________________________ Occupation ______________________________________

Business Address_________________________________________________________ Business Phone______________________________

Emergency Contact Name ______________________________________Relationship_________________ Phone No.____________________

## INSURANCE INFORMATION

Policy Holder Name ___________________________________________________ Relationship to Patient______________________________

Date of Birth _______________ Social Security # ____________________ Policy Holder Employer _________________________________

Address (If different than patient) ________________________________________________________________________________

Medical Insurance Company ____________________________________ ID# _____________________________Group#_________________

Vision Insurance Company _________________________________________ ID# (if applicable) ____________________________________

## AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment directly to all providers of the medical benefits, if any; otherwise payable to me for services rendered by Dr. William White. I understand that I am responsible for any charges incurred by me or any party for whom I am legally responsible. I also agree that in the case of default of payment I will be responsible for any costs incurred in the collection of such account, including reasonable attorney fees and court costs. I hereby waive notice of dishonor, demand, and protest. All exemptions are waived.

I, the undersigned, hereby acknowledge that it is the policy of this office that full payment be made at each visit and I am responsible for payment to Dr. William White for all services rendered to the above patient that are not covered by Medicare assignment, Medicaid, Workman's Compensation, or other benefits agreed by the provider of such services. I certify that the information contained herein is complete and correct. I authorize photocopies of this form to be valid as the original.

**Patient or Guardian Signature** _____________________________**Date**_____________

## RELEASE OF MEDICAL RECORDS AND INFORMATION

To: Custodian of Medical Records

This authorizes you to release to Dr. William White, 5119 Summer Avenue Suite 101, Memphis, Tn. 38122, full and complete medical records, reports, evaluations, consultations or information (collectively referred to as "medical records") you may have in custody concerning the undersigned patient. The undersigned represents and warrants that he/she has full authority to request said records and to agree to all of the conditions recited herein.

The undersigned expressly releases and forever discharges and agrees to indemnify and hold harmless Dr. William White and employees, from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising out of or from the release of any medical records pursuant to this authorization.

**Patient or Guardian Signature** _____________________________**Date**____________

## ACKNOWLEDGEMENT OF PRIVACY POLICY

I acknowledge that I have viewed and been offered a copy of the privacy policy for Dr. William White.

**Patient or Guardian Signature** _____________________________**Date**____________