Arthritis Assoc Of Kingsport PLLC

Three Sheridan Square
Kingsport, TN 37660-7390
(423) 392-6840

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)	ETHNICITY

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE	RACE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#

NAME OF INSURED	SSN#	BIRTHDATE	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

Insurance authorization: I authorize AAK to file insurance for services performed in their office and that payment be made to the providers of service. I authorize the above to contact and/or release my health information to Social Security or other insurance carriers regarding payment for services received at AAK. I am responsible for all financial obligations of health services. If for any reason the account should become delinquent, I agree to pay charges, interest or collection costs and reasonable fees.

SIGNATURE OF PATIENT/GUARDIAN ______________________ DATE ______________