



Lendermon
sports medicine

9950 Crooked Creek Dr. • Collierville, TN 38017
901.850.5756 • Fax 901.850.5911

PATIENT INFORMATION

Please complete all blanks

PATIENT # _____

DATE _____

DOCTOR _____

PATIENT

NAME: LAST FIRST M.I. AGE DATE OF BIRTH RACE

ADDRESS CITY STATE ZIP PHONE

SOCIAL SECURITY NO. MARITAL STATUS: DIVORCED WIDOWED MARRIED SINGLE HAVE YOU BEEN TREATED BY THESE PHYSICIANS BEFORE? YES NO DID YOU SEE THEM FOR THE SAME CONDITION? YES NO DATE

OCCUPATION NAME OF EMPLOYER OR SCHOOL PHONE

EMPLOYER'S ADDRESS CITY STATE ZIP CELL PHONE

EMAIL ADDRESS MAY WE EMAIL PROMOTIONAL/EDUCATIONAL INFORMATION TO YOU? YES NO

WHO REFERRED YOU TO OUR OFFICE: ANOTHER PATIENT ANOTHER PHYSICIAN MED SEARCH YELLOW PAGES "DOCTORS" MEMPHIS VIDEO NAME ADDRESS

PREFERRED PHARMACY: NAME TEL. # DO YOU HAVE AN ADVANCE DIRECTIVE? YES NO

WHO IS YOUR PRIMARY CARE PHYSICIAN? NAME ADDRESS PHONE

IN CASE OF EMERGENCY NOTIFY: NAME STREET ADDRESS, CITY, STATE & ZIP CODE PHONE

RESPONSIBLE PARTY

NAME ADDRESS PHONE

SOCIAL SECURITY NO. OCCUPATION NAME OF EMPLOYER DATE OF BIRTH

EMPLOYER'S ADDRESS CITY STATE ZIP CELL PHONE

INSURANCE

PRIMARY INSURANCE MAIL FORM TO: STREET ADDRESS CITY STATE ZIP PHONE

POLICY HOLDER (IF GROUP, EMPLOYER) INSURED'S NAME GROUP PRIVATE POLICY OR I.D. # GROUP OR OTHER NO.

SECONDARY INSURANCE MAIL FORM TO: STREET ADDRESS CITY STATE ZIP PHONE

POLICY HOLDER (IF GROUP, EMPLOYER) INSURED'S NAME GROUP PRIVATE POLICY OR I.D. # GROUP OR OTHER NO.

PLEASE READ AND SIGN

In order to control our costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees. A billing fee may be assessed after 60 days.

My payment will be made for services rendered by: (please check one)

CASH CHECK CREDIT CARD

Signed: _____ Date: _____

AUTHORIZATION

I hereby authorize Lendermon Sports Medicine to release any information concerning my treatment and hereby irrevocably assign to them all insurance benefits for my treatment. I am aware that my visit may require orthopedic supplies (DME) and I understand that I am financially responsible for payment of all charges at the time they are rendered including any charges in excess of my insurance reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying my insurance coverage & pre-certifying my benefits with my insurance company. I also understand that I am responsible for reasonable collection costs and / or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original.

I acknowledge receipt of the Notice of Privacy Practices that was given to me by this Practice. I give my permission to Lendermon Sports Medicine for medical treatment including, but not limited to, examination, injections, blood tests, diagnostic testing or medical procedures deemed necessary and appropriate for diagnosis and treatment.