RAINES FOOT CLINIC

PATIENT'S FULL NAME _____
DATE OF BIRTH _____ AGE _____ SEX F __ M __ SS# _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL _____
Email _____
MARITIAL STATUS S __ M __ D __ W __ STUDENT: YES NO
EMPLOYMENT: FULL TIME_____ PART TIME_____ NOT_____ RETIRED_____
EMPLOYER _____ OCCUPATION _____
SPOUSE OR PARENT #1 _____ DATE OF BIRTH _____
SS# _____ EMPLOYER _____ WORK PHONE _____
Address if different _____ CELL PHONE _____
PARENT #2_____ DATE OF BIRTH _____
SS# _____ EMPLOYER _____ WORK PHONE _____
Address if different _____ CELL PHONE _____

RESPONSIBLE PARTY (if other than self) _____ DATE OF BIRTH _____
RELATIONSHIP TO PATIENT _____ PHONE _____
ADDRESS IF DIFFERENT _____
SS# _____ EMPLOYER _____ WORK PHONE _____
CELL PHONE _____

- **How did you know about Raines Foot Clinic?**_____
- **Who is your Primary Care Physician?** _____ **Phone** _____
- **What Pharmacy do you use?** _____ **Phone** _____

IN CASE OF EMERGENCY CONTACT (someone with different phone number than listed above)
NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE _____
CITY _____ STATE _____ ZIP _____

****PRIMARY INSURANCE**
NAME OF INSURANCE _____ PHONE _____
POLICY HOLDER _____ RELATIONSHIP _____
ID# _____ GROUP# _____ DOB OF POLICY HOLDER _____
COPAY _____ DEDUCTIBLE _____ **EDI PAYOR #**_____
****SECONDARY INSURANCE**
NAME OF INSURANCE _____ PHONE _____
POLICY HOLDER _____ RELATIONSHIP _____
ID# _____ GROUP# _____ DOB OF POLICY HOLDER _____

I hereby authorize the release of any pertinent information to my insurance company upon request and authorize my doctor to act as my agent in helping me obtain payment from my insurance. I assign all medical/surgical benefits on my behalf to RAINES FOOT CLINIC. I authorize use of this form on all my insurance submissions and permit a copy of this authorization to be used in place of the original. The undersigned severally agree, whether signing as a patient or otherwise, that in consideration of the services rendered to patient, payment of the account is guaranteed by the undersigned. While any insurance or other protection related to the account may be hereby assigned to and payable directly to us, the undersigned clearly understands that the obligation to pay the bill is primarily on the patient and the undersigned. While insurance received by us will applied to the patient's account, any part of the account not so paid by the insurance is nevertheless owing and should it be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees, cost and other expenses will be paid by the undersigned. The patient agrees that in the event his/her account is turned over for collections, and a lawsuit is instituted, that Obion County, Tennessee is the appropriate forum for such lawsuit, and the patient hereby consents to the jurisdiction of the Obion County, Tennessee courts.

PATIENT/GUARANTOR'S SIGNATURE _____ **DATE** _____

It is our practice to send a treatment summary letter to your primary care provider.