OLIVE BRANCH
FAMILY MEDICAL CENTER

THIS FORM MUST BE COMPLETED IN FULL

PATIENT INFORMATION

PLEASE PRINT

Patient Name (Last, First, MI) _____ Age _____ Marital Status M ❑ S ❑ D ❑ W ❑

Address _____ City / State _____ Zip _____

Home Phone _____ DOB ____ / ____ / ____ Sex: M / F Soc. Sec. # _____ - _____ - _____

Occupation _____ Employer Name _____

Address _____ City _____ St ____ Zip _____ Phone _____ Ext _____

Name of Spouse or Parent _____ DOB ____ / ____ / ____ SS# _____

Address _____ City _____ St ____ Zip _____ Phone _____ Ext _____

Email address if known: _____ Referred by: ❑ Friend ❑ MD ❑ Phone Book ❑ Other

RESPONSIBLE PARTY / GUARANTOR

Responsible Party's Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other _____ Responsible Party's Date of Birth ____ / ____ / ____

Responsible Party's Name (Last, First, MI) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ SS# _____

Employer _____ Address _____

Responsible Party's Spouse's Name _____ DOB ____ / ____ / ____ Work Phone _____

INSURANCE INFORMATION

Insurance Company _____ I.D. Number _____ Group # _____

Relationship to Cardholder Self ❑ Spouse ❑ Child ❑ Other ❑ _____ Cardholder's DOB ____ / ____ / ____

Cardholder's Name _____ Cardholder's Address _____

City _____ St _____ Zip _____ Cardholder's Home Phone _____

Cardholder's Employer _____ Cardholder's Work Phone _____ SS# _____

What hospital are you required to use? _____

PERSON TO CONTACT IN CASE OF EMERGENCY - MUST COMPLETE THIS SECTION

Name _____ Phone _____

Address _____ Realtionship _____

I understand that OLIVE BRANCH FAMILY MEDICAL CENTER is not a provider for MS Medicaid or TennCare. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including all private insurance and other health plans to OBFMC. This assignment will remain in effect until revoke by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize assignee to release all information to secure payment. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay interest on any past due monthly account balance. Should my account be placed with a collection agency or referred to an attorney for purposes of seeking judicial relief, I agree to pay all costs of collection, reasonable attorney's fees, expenses, all costs of court, plus pre and post-judgment interest on any judgment. PAYMENT IS DUE AT TIME OF SERVICE.

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SIGNATURE OF PATIENT/GUARDIAN DATE