



Date _____ PHYSICIAN _____ Account Number _____

Patient's Name Mr./Mrs./Ms. _____
Last First Middle

M ___ F ___ Age _____ Date of birth _____ **Patient** Social Security # _____

Parent or guardian Name (if patient under 18) _____ Driver's Licensee _____

Mailing address _____
Street City State Zip code

Actual Street address if mailing address is a P.O. Box _____

Home Phone _____ Work Phone _____ Cell number _____

In case of an Emergency contact (name) _____ **phone** _____

Patient's Employer _____ Occupation _____

Employer's address _____
Street City State Zip code

INSURANCE INFORMATION:

Subscriber name _____

Social Security number _____ Date of birth _____

Subscriber Employer _____ Phone number _____

Address _____

If work related accident name of person to contact _____

About X-rays: All x-rays taken are the property of Transylvania Physician Services, Inc.. X-rays are a part of your medical file and must be maintained as part of your medical record. The cost of x-rays includes taking the x-ray film, supplies, processing and interpretation.

Financial Responsibility/ Medical Records

I have read and fully understand the financial policy established by Transylvania Physician Services, Inc.. I agree that insurance payments are to be paid to Transylvania Physician Services, Inc. on my behalf. I understand that I am financially responsible for all charges not paid by insurance. In the case of a minor, the child's guarantor is responsible for the account. Patient portion of charges and co-pays are due at the time services are rendered.

Patient (Parent or Guardian if minor) signature _____
Relationship to patient _____ **SS#** _____ **Printed name** _____