Roy C. Terry, MD   Martha George, MD   John D. Tullos, MD
Beau Cassidy, FNP   Greg Glover, PA-C
101 Physician's Way | Lebanon, TN 37090
(615) 449-0990 | Fax (615) 449-4835
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Patient Information

Legal Name : ______________________ Sex: ❒ Male ❒ Female

Date of Birth: ____________ Age: ________ Social Security #: ______________

Home Address: ______________________

City: ______________ State: ________ Zip code: ____________

Home Phone: (________) ______________ Cell: (________) ______________

Work Phone: (________) ______________ Email: ______________

Responsible Party: ______________________

Relationship: ______________ Phone: (______) ______________

Address/City/State: ______________ Zip code: ____________

Employer: ______________ Occupation: ______________

Employer Address/City/State: ______________ Zip code: ____________

Race ____________ Ethnicity ____________ Primary Language ____________

Insurance Information

Please complete the information below if someone other than the patient holds the health insurance plan

Insured Legal Name : ______________ Birth Date: ________ Social Security #: ____________

Relationship to Patient: ______________ Phone: (________) ______________

ID #: ______________ Group #: ______________

Address/City/State/Zip: *(if different from patient)* ______________________

Employer: ______________ Employer Phone: (________) ______________

Employer Address/City/State: ______________ Zip code: ____________

I have been presented with a copy of Notice of Privacy Practices and understand that, under the Health Insurance Portability & Accountability Act of 1996 that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to - conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications. I understand that Tennessee Orthopedics reserves the right to modify the Privacy Practices outlined in the notice. I understand that I may revoke the consent in writing at any time, except to the extent that you have taken action relying on this consent. I understand that it is the patient's responsibility to address any outstanding claims on my account.

Signature ______________________ Date ____________