



Roy C. Terry, M.D.

Orthopedic Surgeon

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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 _____