1035 14th Avenue North Nashville, Tennessee 37208 (615) 327-9400	230 Dover Road Clarksville, Tennessee 37042 (931) 920-5000	739 President Place Smyrna, Tennessee 37176 (615) 984-4290

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION (PLEASE GIVE YOUR IDENTIFICATION TO THE RECEPTIONIST)

Patient's Last name:	First:	MI:	Social Security#
Have you been seen at one of our locations before? ☐ Yes ☐ No	Birth date:	Age:	Sex: ☐ M ☐ F
Address:			ZIP Code:
Home Phone Number:	Cell Phone Number	Work/Alternate Phone Number	

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.:	Alternate phone no.:

DEMOGRAPHIC INFORMATION

School Based?	Migrant Farm Worker?	Homeless?	Veteran?	Are You Hispanic or Latino?
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

What is your race? ❑ Asian ❑ African-American ❑ White ❑ American Indian ❑ Native Hawaiian ❑More than one race ❑Refuse to Report

PREFERRED LANGUAGE: ☐English ☐Spanish ☐Arabic ☐Other:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

What insurance coverage do you have:	☐Private Insurance ☐ TennCare ☐Medicare ☐Other	
Name of Primary Insurance:		
Subscribers Name:	Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other:	
Subscribers Birthdate	Subscribers Social Security Number	
Group Name	Policy Number:	Copayment:
Name of Secondary Insurance:		
Subscribers Name:	Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other:	
Subscribers Birthdate	Subscribers Social Security Number	
Group Name	Policy Number:	Copayment:

Would you like to apply for the Sliding Fee Discount Program? ❑ Yes ❑ No

Do you have a living will or advanced directive? ❑ Yes ❑ No
If you do not have a living will or advanced directive ask our staff for information on this important subject.

CONSENT TO TREAT

The preceding information is true to the best of my knowledge. I request Matthew Walker Comprehensive Health Center, Inc. to provide me and/or my family member with medical, dental and/or diagnostic treatment. I understand that there is no guarantee or assurance as to the results of any treatment provided. I acknowledge my responsibility to pay for this care according to the fees established. I authorize assignment of benefits for medical, dental and or/diagnostic care and the services associated with my visit to be paid to Matthew Walker Comprehensive Health Center, Inc. I understand that I will be responsible for any fees that are not paid by my Insurer. I also agree that if I do not have any insurance that I will be responsible for my fees. I agree that I have been provided information regarding advanced directives, living will, durable power of attorney and the notice of privacy practices.

Patient/Guardian signature *Date*

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I agree to allow Matthew Walker Comprehensive Health Center, Inc. to contact me in the following methods regarding my private health information, evaluation and treatment.

PRIVACY AND COMMUNICATION PREFERENCES		
You may leave messages on my:	☐Cell phone: ☐Home phone: ☐Work phone:	
You may text me information regarding my appointments (reminders/cancellations) on my:	☐Cell phone:	
You may email information about my appointments or other general information to:	Email address:	
You may send information regarding my treatment to:	☐Home address: ☐Work address:	

I authorize Matthew Walker Comprehensive Health Center, Inc. to discuss my healthcare information (which may include history, diagnosis, labs, tests results, treatment and other health information) with the contacts listed below.
I understand that by leaving the space blank I am indicating that I do not want any information released to anyone other than required or permitted by law.

Name:	Relationship:
Phone Number:	Address:
Name:	Relationship:
Phone Number:	Address:

I acknowledge that I have read and consented to the communication provided by this form. I understand the risk associated with the different methods of communication, especially email and texting, and consent to the conditions, restrictions and patient responsibilities. I understand that it is my responsibility to keep my related passwords and access to information confidential.

Patient Name Printed:______________________________________ Date: ____________________

Patient Signature:____