TN Vascular – Dr. Charles S. Drummond, III

925 S Church St Suite C-200

Murfreesboro, TN 37130

Date: ____________

Name: ____________________________________ Nickname: ________________
Address: ____________________________________ City: ___________________ State: _____ Zip _________ Phone: ________________ (W) _______________ (C) ________________ (H) Best time to contact: AM ___ P.M. ____ at my Work _____ Cell _____ Home_____
Date of Birth: _____________________ Social Security #: ______________________
Check Appropriate Box:
___Minor___Single___Married___Widowed___Separated___Divorced
Spouse or Parent's Name: _____________________ Employer: ____________________
Whom may we Thank for referring you? ______________________________________
Emergency Contact: _________________________ Relationship to patient: ___________ Phone: ___________________ Email address:_______________________________
Primary Care Doctor: _____________________ Referring Physician: _______________
Right Handed: ________ or Left Handed: ________

Responsible Party Information to Pay
Relationship to Patient: ___ Self ___ Parent ___ Spouse ___ Other
Name: _______________________________ Pt. Relationship: _________________
Address: _______________________ City: _______________ State: ___ Zip: ______
Phone: _______________ (W) _______________ (H) _____________________ (C)
Employer: ___________________________ Social Security #: __________________

Insurance Information
Name of Insured: _____________________________ D.O.B. ________________
Soc. Sec.# _____________________ Employer ___________________________
Employer Address: _____________________ City: ___________ State: ____ Zip: ___
Insurance Provider: _____________________ Group #: ____________ ID#: ________
Provider Address: ___________________________ Provider Phone: ______________

*****DO YOU HAVE ADDITIONAL INSURANCE? ____ YES _____ NO
IF YES, PLEASE COMPLETE BELOW*****

Name of Insured: _________________________________ D.O.B. _______________

Soc. Sec.# ___________________________ Employer___________________________________
Employer Address: ____________________________________ City: ______________________
State: _____ Zip: _______
Insurance Provider: ___________________________   Group#: ________________ ID# ______
Provider Address: ___________________________________ Provider Phone: _____________

I hereby assign payment directly to Wound Care NOW-Manchester Clinic for all surgical and /or medical benefits payable to me for services rendered but not to exceed the charges. Any unpaid deductible, copay, or other balance not paid by insurance is due payable in full within 90 days from the date of service regardless of any insurance pending. Any unpaid balance will be subject to collections.

Signature of Patient (or Parent if under 18 yrs. old) ____________________Date _______

PHARMACY USED: ____