TN Vascular – Dr. Charles S. Drummond, lll

315 NW Atlantic St

Tullahoma, TN 37388

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: _____