

Beating Pulse Family Medicine

529 Brandies Circle • Murfreesboro, TN 37128



Date: _____/_____/_____

Thank you for choosing our office. In order to serve you better, please fill out the following.

Patient's Last Name: _____	First: _____	Middle Initial: _____
Mailing Address: _____		
City: _____	State: _____	Zip: _____ SS#: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone: _____	Work: _____ Cell: _____
Date of Birth: _____	Age: _____	Employer: _____
Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> Div <input type="checkbox"/> W	Spouse/Parent: _____	
Spouse/Parent Employer: _____	Work Phone: _____	
Email: _____	Preferred Method of Contact: <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email	
Race: <input type="checkbox"/> Caucasian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> African American <input type="checkbox"/> Other _____
Ethnicity: <input type="checkbox"/> Hispanic	<input type="checkbox"/> Non Hispanic	<input type="checkbox"/> Declined

PRIMARY INSURANCE COMPANY NAME _____
Policy Holder's Name: _____ D.O.B. _____ SS# _____
Relationship to Patient: _____ ID# _____ Group # _____

SECONDARY INSURANCE COMPANY NAME _____
Policy Holder's Name: _____ D.O.B. _____ SS# _____
Relationship to Patient: _____ ID# _____ Group # _____

NEAREST RELATIVE NOT IN HOUSEHOLD / OR EMERGENCY CONTACT
Name: _____ Relation: _____ Home Phone: _____

Signature: _____ **By signing you agree to allow your provider to access your prescription history.**

Advanced Directive: All adults in health care settings in the state of Tennessee have the right to an "advanced directive". This is a written or oral statement made and witnessed in advance of a serious illness or injury, stating how medical decisions will be made. An advanced directive enables you to state your choice or name someone to make your choice for you, if you should become unable to make decision about your medical treatment. An advanced directive can enable you to make decisions. Do you have a Living Will? Yes No (If yes, please provide this office with a copy. If no, and you would like a living will, we have one available.)

Signature: _____ **Date:** _____

I authorize the release of medical information necessary to obtain payment of medical benefits from my health insurance company. I also authorize my insurance company to pay Beating Pulse LLC any medical benefits due for services rendered.

I understand that I am responsible for paying deductibles, co-pays and any other charges not paid by my insurance company.

CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT.

Our policy is that payment is expected in full at the time services are rendered, unless other financial arrangements are made **in advance**. If you participate in one of our contracted insurance programs, we will bill your insurance company. Verification of your insurance, deductible, and co-payment in advance of your office visit will be necessary. To the best of my knowledge, the above information is correct. I understand and agree to comply with the practice's financial policy.

Signature: _____ **Date:** _____

Print Name: _____