NASHVILLE ENDOSCOPY CENTER
300 20th Avenue North, 8th Floor
Nashville, Tennessee 37203
Phone: 615.284.1335 / Fax: 615.284.1316

PATIENT INFORMATION

Today's Date: _____/_____/_____ NEC Account #: _____ NMG Account #: _____

Thank you for choosing Nashville Endoscopy Center. Please complete the following information.

REFERRED BY

☐ Another Patient ☐ Friend/Relative ☐ Physician

Referring Physician's Name: _____

Primary Physician's Name, if different from above: _____

PATIENT INFORMATION

Patient Name: _____
(Last) (First) (Middle)

SS#: _____ Birth Date: _____/_____/_____ Age: _____ Gender: _____

Address: _____
(Street)

_____
(City) (County) (State) (Zip Code)

Phone: _(_____)_____ Work Phone: _(_____)_____

Mobile Phone: _(_____)_____ Beeper: _(_____)_____

Employed By: _____ Occupation: _____

Business Address: _____

_____ Business Phone: _(_____)_____

Spouse's Name: _____

Employed By: _____ Phone: _(_____)_____

Name and Address of Person Responsible for Payment: _____

_____

Phone Number of Nearest Relative or Friend Not Living at Same Address: _(_____)_____

AUTHORIZATION

I request that payment of authorized **Medicare or other insurance benefits** be made to either me or on my behalf to NASHVILLE ENDOSCOPY CENTER for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration (Medicare) or other insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
(Patient's Signature) (Date)

I request that payment of authorized **Medigap (Medicare supplement) benefits** be made on my behalf to NASHVILLE ENDOSCOPY CENTER for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (Medigap insurance) any information needed to determine these benefits payable for related services.

_____ _____
(Patient's Signature) (Date)