ALAN F. SHIKOH, M.D.
KIMBERLY M. GARLAND, NP-C
721 GLENWOOD DRIVE, SUITE W473
CHATTANOOGA, TN 37404

DATE_____

NEW PATIENT/UPDATE INFORMATION – PLEASE FILL IN ALL BLANKS USING BLACK OR BLUE INK

Patient Name
Last: _____

First: _____ Middle: _____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth _____ S.S. #_____

Sex: ____M ____ F Marital Status: ___M, ___S, ___W, ___D

Name of Spouse or Guarantor
Last: _____

First: _____Middle____

Address:_____

City : _____State: _____Zip_____

Home Phone: _____ Cell: _____

Date of Birth _____ S.S. #_____

Relationship to patient: _____

E-Mail Address: _____

PCP/Family Doctor: _____

Dr. Referred By: _____

Spouse or Guarantor Employment
____Full-Time ___Part __Retired __NA

Employer Name: _____
Employer Phone: _____

Patient Employment
____ Full-time ____ Part-time ____ Retired ____ Not Employed ____ Part-time Student ____ Full-time Student
Employer Name: _____ Phone: _____

Employer Address: _____ City: _____
State: _____ Zip: _____

Pharmacy
Name: _____ Address: _____ City: _____
State: _____ Zip: _____

Phone Number: _____

Primary Insurance Information
Insurance Company: _____ Insured Name if different from patient: _____

Address to mail claims to: _____ City: _____
State: _____ Zip: _____

Policy Number: _____ Group Number: _____
Card Effective Date: _____

Secondary Insurance Information
Insurance Company: _____ Insured Name if different from patient: _____

Address to mail claims to: _____ City: _____
State: _____ Zip: _____

Policy Number: _____ Group Number: _____
Card Effective Date: _____

I authorize payment of medical benefits to Alan F. Shikoh, M.D., P.C. for services rendered. I authorize the release of any medical information necessary to process insurance claims and certify that the information contained herein is correct. Medicare Patients: I authorize payment of Medigap benefits by the Medigap insurer as listed be made on my behalf to Alan F. Shikoh, M.D., P.C. for services rendered. Except under certain circumstances (Worker's Compensation; governmental programs such as Medicare or TN Care; and physician participating health insurance plans). I will be responsible for the full payment amount of the charges. I agree to pay any collection fees if legal action is necessary in the collection effort of this account.

X _____ _____

Signature of Patient or Guarantor if Patient is a Minor **Date**