Chattanooga Spine and Body

Homero Rivas, II, MD

5617 Hwy 153, Suite 103
Hixson, TN 37343

Phone: 423-485-3226
Fax: 423-485-3302

Patient Demographic Form

Please Print All Information Below. Thank you.

Date: _____

Patient's Name: _____ **Gender:** ___ Male ___ Female
Last First MI

Patient's Mailing Address: _____
Street Address City State Zip

Home Phone: ( )_____ **Cell:** ( )_____

Date of Birth: _____ **Social Security #:** _____

Marital Status: ____Single ____Married ____Divorced ____Widowed **Spouse Name:** _____

Employer: _____ **Phone:** ( ) _____

Employer Address: _____
Street City State Zip

Race: ____African American ____American Indian ____Asian ____White Other: _____

Ethnicity: ____Hispanic Origin ____Non-Hispanic ____Type-Unknown

Preferred Language: _____ **Email Address:** _____

If patient under 18 years of age or full-time student, please complete the following:

Parent or Guardian Name: _____ **Social Security #:** _____

Phone (if different from above): _____(day)_____(evening)

Address (if different from above): _____
Street Address City State Zip

Primary Care Physician: _____ **Phone:** ( )_____

Referring Physician (if different): _____ **Phone:** ( )_____

How did you find out about Chattanooga Spine and Body / Homero Rivas II, MD?

_____ Former Patient / Old Office

_____ Website / Internet

_____ MD Referral: _____

_____ Friend / Family Referral

_____ Advertising - TV / Radio / Newspaper

_____ Other: _____

_____

Primary – Insurance Coverage Information:

Insurance Co Name: _____

Insurance Co Address: _____
Street/PO Box City State Zip

Policy ID#: _____ **Group#:** _____

Policy Holder's Name: _____
Last First MI

Policy Holder's Address: _____
Street City State Zip

Date of Birth: _____ **Social Security #:** _____

Patient's Relationship to Policy Holder: ____Self ____Spouse ____Child ____Other:_____

Secondary – Insurance Coverage Information:

Insurance Co Name: _____

Insurance Co Address: _____
Street/PO Box City State Zip

Policy ID#: _____ **Group#:** _____

Policy Holder's Name: _____
Last First MI

Policy Holder's Address: _____
Street City State Zip

Date of Birth: _____ **Social Security #:** _____

Patient's Relationship to Policy Holder: ____Self ____Spouse ____Child ____Other:_____

Worker's Compensation Injury: ____ Yes ____ No **Date of Injury:** _____

Employer at time of Injury: _____

Employer Address: _____
Street/PO Box City State Zip

Employer Phone: ( ) _____ **Describe your injury (including body part involved):**

_____

Case Manager: _____ **Phone#:** ( ) _____

Acknowledgement/Authorization: I hereby acknowledge and understand that I am financially responsible for all charges. In the event of default, I agree to pay all costs of collection and reasonable attorney fees.

I acknowledge that I have reviewed/received this office's notice of privacy practices, which explains how my medical information will be used and discussed.

I certify the above information is true and correct to the best of my knowledge, and I consent to any medical or surgical treatment rendered the patient under general or special instructions of the physician.

Signature: _____ **Date:** _____