Office of Lindsay Keith, M.D.
615-900-2621 | LindsayKeith.com
1830 Heritage Park Plaza Murfreesboro, TN 37129

PATIENT INTAKE FORM

TODAY'S DATE: ____________ DATE OF BIRTH: ____________

FIRST NAME: ____________

MIDDLE NAME: ____________

LAST NAME: ____________

STREET ADDRESS: ____________

CITY: ____________ STATE: ________ ZIP: ________

HOME PHONE: ____________ CELL PHONE: ____________

LANGUAGE: ________ **RACE:** ________ **ETHNICITY:** ________

SOCIAL SECURITY NUMBER ________ - ____ - ________

EMAIL ADDRESS: ____________

PHARMACY NAME: ____________

PHARMACY ADDRESS: ____________

PATIENTS EMPLOYER: ____________

WORK PHONE: ____________

SPOUSE'S NAME: ____________

SPOUSE'S DOB: ____________

SPOUSE'S EMPLOYER: ____________

SPOUSE'S WORK PHONE: ____________

WHERE DO YOU PREFER TO RECEIVE CALLS? ☐ HOME ☐ CELL ☐ WORK

MAY WE LEAVE INFO ON YOUR VOICEMAIL? ☐ NO ☐ YES

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EMERGENCY CONTACT

NAME: ______________________________

PHONE: ______________________________

RELATIONSHIP: ______________________________

BILLING INFORMATION:

(Who will be responsible for services not covered by insurance?)

NAME: ______________________________

RELATIONSHIP: ______________________________

DATE OF BIRTH: ______________________________

PHONE: ______________________________

ADDRESS: ______________________________

I hereby authorize you to release any information including the diagnosis and record of any treatment or examination rendered to me during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Lindsay Keith, MD PLLC. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf.

PATIENT SIGNATURE: ______________________ DATE: ______________