Bancroft O'Quinn, Jr., M.D.
1405 Baddour Parkway, Suite 106
Lebanon, TN 37087

Referred By: ______________________________

☐Physician ☐Relative ☐Friend ☐Yellow Pages ☐Insurance ☐Other (Please Specify): ______________

Name (Please provide your FULL middle name): ______________________________

Email: ____________________ Birthdate: ______________ ☐Male ☐Female

Address: ______________________________
(Street) (City) (State) (Zip)

Social Security Number: ______________ Employer: ______________

Home Phone Number: (_____) ______________ Work: (_____) ______________ Cell: (_____) ______________

Spouse's Name: ______________ Spouse's Work Phone: (_____) ______________

Spouse's Employer: ______________________________

Emergency Contact: ______________ Phone: (_____) ______________
(Someone who does not live with you.)

PRIMARY INSURANCE COMPANY: ______________________________

Name of Person Who Carries Insurance: ______________________________

Birthdate: ______________ Social Security Number: ______________ Relationship to Patient: ______________

SECONDARY INSURANCE COMPANY: ______________________________

Name of Person Who Carries Insurance: ______________________________

Birthdate: ______________ Social Security Number: ______________ Relationship to Patient: ______________

PLEASE READ CAREFULLY:
I (we) acknowledge full responsibility for all charges. I (we) agree to pay for office calls at the time of service unless services are covered by an insurance company for which Dr. O'Quinn is a provider. I (we) are responsible for any services not covered by insurance. After sixty (60) days, I (we) agree to pay a monthly service charge of one and one half percent (1 ½%) of any unpaid balance. In the event my bill becomes subject to collection activities, I (we) shall be responsible for all collect costs, including but not limited to court costs and attorney's fees. I authorize the release of any information necessary to process claims. I authorize the release of payment for all charges directly to Dr. O'Quinn unless they are paid for at the time of service. I authorize the release of my medical information to the referring physician I have listed above.

Signature: ______________________________ Date: ______________