QUINN HEALTHCARE, PLLC
" Providing quality healthcare to you and your family."

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ Social Security # _____

Address: _____

City:_____ State: _____ ZIP: _____

Employer: _____

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

Emergency Contact: _____ Phone: (_____) _____

Birth Date: _____ Sex: _____ Marital Status:_____ Race:_____

Ethnicity: (circle one) Hispanic/Non-Hispanic Primary Language _____

E-mail Address: _____

Spouse SS#_____ Spouse Employer: _____

Primary Pharmacy: _____ Phone: (_____) _____

PERSON RESPONSIBLE FOR BILL (if different from above, please complete**)**

Guarantor's Name: _____

Social Security Number: _____Birth Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

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

Employer: _____

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INSURANCE INFORMATION

Primary Insurance Company: _____

Address: _____
City: _____ State: _____ZIP:_____

Insured Name: _____Relationship: _____DOB: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Address: _____

City: _____ State: _____ ZIP: _____

REFERRAL: Referred to our Clinic by: _____

Phone Number: _____ FAX Number:_____

BENEFITS AUTHORIZATION

I authorize treatment of the patient named above and agree to pay all fees and charges. I request that payment of authorized Medicare, Medicaid or other third party insurances be made to Quinn Healthcare, PLLC if assignment is accepted, in which case I agree to pay any deductible, co-payment or disallowed charges. If assignment is not accepted, then I agree to pay the entire amount due. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or the Division of Medicaid or their Fiscal Agent or any third party insurance or any information needed to determine these benefits. (A copy of this assignment is as valid as the original.)

Patient or Guarantor Signature: _____Date:_____

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QUINN HEALTHCARE, PLLC

Phone: 601-487-6482; Fax: 601-487-6528

AUTHORTITY TO RELEASE/OBTAIN INFORMATION

Patient's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____/_____/_____

I understand and hereby authorize Timothy M. Quinn, M.D. to release or receive the information described below:

Check which reports can be released/received by Timothy M. Quinn, M.D.

( ) Discharge Summary Report
( ) Operative Report
( ) EKGS
( ) Radiology Report (x-rays)
( ) Consultant Reports
( ) History and Physical Report
( ) Lab Report
( ) Other (specify) _____

Release To:	**Obtained From:**	**Released by Dr. Quinn**
Dr. Timothy M. Quinn	_____	_____
768 North Avery Blvd	_____	_____
Ridgeland, MS 39157	_____	_____
	_____	_____

I understand that this authorization authorizes the release of all medical records including PSYCHIATRIC, ALCOHOL, DRUG ABUSE, and HIV/AIDS RECORDS. The use of this information may be protected by Public Law 93-255 Section 408, Public Law 93-282, Section 333, or Federal Regulation 42 CFR, Part 2. The information provided is confidential and any re-disclosure by the recipient is prohibited.

Signature: _____ Date: _____

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PAST MEDICAL HISTORY

Do you now or ever had: (check all that apply and give date diagnosed)

___ Diabetes ___Stroke ___Goiter ___Thyroid Disease ___Glaucoma

___ Heart Disease ___Osteoporosis ___Cataracts ___Cancer

___ High Blood Pressure ____HIV/AIDS ___Liver Disease ___ Lung Disease

___ Other significant illness and date of diagnosis

(Explain) _____

___ None of the Above _____

PAST FAMILY HISTORY

Do your parents or sibling(s) have any of the following: (please check all that apply)

___ Diabetes ____Obesity ___High Blood Pressure ___ Heart Disease

___ Cholesterol ____Thyroid Cancer ___Alcoholism

___ None of the Above _____

PAST SURGERIES

1. _____ **2.** _____

3. _____ **4.** _____

None of the Above _____

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QUINN HEALTHCARE, PLLC

Timothy M. Quinn, M.D.
Alisha Mcarthur Wilkes, RN, MSN, FNP-C
Kishina Sanders, FNP-C, FMCSA Certified Medical Examiner
LaMeka Miller, FNP-C

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, have received a copy of the **QUINN HEALTHCARE, PLLC**, Notice of Privacy Practice.

_____ _____

Signature of Patient Date