Teki S. Hegwood, M.D.

Date:_________________

Referred By:	Street Address, City ,State, Zip	Phone#

Patient Name	Marital Status	DOB	Age	Social Security #
Street Address	City, State, Zip			Home Phone#
Mailing Address, if different than above				Cell phone #
Employer	Occupation	How long Employed		Business Phone#
Spouse or Parents Name	Date of Birth			Social Security#
Spouse or Parents Employer	Occupation			Business Phone #
Nearest Relative, Other than above	Relationship			Phone #
Family Physician Phone#	Emergency Contact Phone#			
Have any members of your immediate family been treated by our physicians before?				
If you would like to receive Health News updates please provide your email address.				

Primary Insurance

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Name of Insurance

____

Name of Insured DOB

Secondary Insurance

____

Name of Insurance

____

Name of Insured DOB

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please Read and Sign)

I hereby authorize Teki Hegwood, M.D. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician's all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Date__________________Signature________________________________

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments for major care. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made. I understand that there will be a $35.00 cancellation fee if notice is not given within 24 hour.

Thank you, Dr. Hegwood