**SUSAN C. BRILEY, M.D.**
**2021 Church St Plaza II Ste#506 Nashville, TN 37203**
**615-284-4224 (Phone)………………………..615-284-4225 (Fax)**

Patient Name: _______________________________________________ DOB: ____________ AGE: __________

Physical Street Address: _____________________________________________________________________

Mailing Address: ___________________________________________________________________________

City: ___________________________________ State: ________ Zip Code: ______________________________

Social Security Number: _________-______-_________ Marital Status: __________ Sex: __________________

Race: ____________________________ Ethnicity: ______________ Language: ___________________________

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

Email Address: _____________________________________________________________________________

Emergency Contact: ______________________________________ ER Contact Phone: (_____)______________

Who Recommended You to This Office: ___________________________________Phone:__________________

Primary Care Physician: _________________________________________________Phone:__________________

Employer's Name: __________________________________________ Work Phone: (______)_______________

Spouse Name: ________________________________________ DOB: _________SSN#: ___________________

Pharmacy Name: __________________________________________ Phone: (_____)______________________

Pharmacy Address: _________________________________________________________________________

**Insurance Information *Please provide Insurance Card and Photo ID to Receptionist** (Necessary forms will be completed to help expedite claims. However, the patient or responsible party is responsible for all fees, regardless of insurance coverage.)

Primary Insurance Company's Name: ___________________________ Providers/Pre-Cert# ________________

Name of Policy Holder: __________________________________________ DOB: ___________________________

Insurance ID Number: ____________________________________Group Number: _________________________

Secondary Insurance Company's Name: _____________________________________________________________

Name of Policy Holder: _______________________________________________ DOB: _______________________

Insurance ID Number:__________________________________________ Group Number: ___________________

I hereby authorize my insurance benefits to be paid directly to Dr. Susan C. Briley for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefit. My signature below also serves as an authorization for copies of any and all medical records concerning my medical condition to be sent to Dr. Susan C. Briley.

Signature of Responsible Party: ________________________________________ Date: ________________________