SUSAN C. BRILEY, M.D.
2004 Hayes St Ste#550 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 consent to view prescription history from external sources and 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:_____