

R. Hunter Jennings, M.D.  
Robert M. Magill, M.D.  
Jonathan R. Thompson, M.D.

Larimar Medical, PLLC  
307 Manufacturers Road, Ste 201  
Chattanooga, TN 37405

**CLIENT INFORMATION (PLEASE PRINT)**

Date: \_\_\_\_\_

Full Legal Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Mailing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F Marital Status: M S W D

NEXT OF KIN \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Wk/Cell (\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Wk/Cell (\_\_\_\_) \_\_\_\_\_

GUARANTOR NAME (If client is minor child) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Primary Care Physician (Full Name) \_\_\_\_\_

Address/Phone \_\_\_\_\_  
Street City State Zip Phone

Referring Physician (Full Name) \_\_\_\_\_

Address/Phone \_\_\_\_\_  
Street City State Zip Phone

If this visit is eligible for insurance reimbursement, please fill out the following:

PRIMARY INSURANCE \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Employer's Address \_\_\_\_\_

Subscriber's SSN \_\_\_\_\_ Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Employer's Address \_\_\_\_\_

Subscriber's SSN \_\_\_\_\_ Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

**Do you have a living will? \_\_\_\_\_ If so, please provide a copy.**

I, the undersigned, give my authorization to treat and assign directly to R. Hunter Jennings, Robert M. Magill or Jonathan R. Thompson, M.D., all medical benefits, if any, otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges other or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of the signature on all insurance submissions. I authorize release of medical information for treatment.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_