PATIENT REGISTRATION FORM

QUINN HEALTHCARE, PLLC

Timothy M. Quinn, M.D.

PATIENT INFORMATION

Patient's Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Cell Phone: (_____)_____

Emergency Contact & Phone # _____

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

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

E-mail Address: _____

Spouse Name: _____ Spouse DOB: _____

Spouse SS#: _____ Spouse Employer: _____

Primary Pharmacy: _____ Phone # (____)_____

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

Guarantor's Name: _____ Social Security #: _____
Date of birth:_____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Cell: _____

Employer: _____

QUINN HEALTHCARE, PLLC

Timothy M. Quinn, M.D.

INSURANCE INFORMATION

Primary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____ Relationship: _____ DOB: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____ Relationship: _____ DOB: _____

Policy Number: _____ Group Number: _____

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: _____

QUINN HEALTHCARE, PLLC

Timothy M. Quinn, M.D.
Phone: 601-487-6482; Fax: 601-487-6528

AUTHORITY 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: _____

QUINN HEALTHCARE, PLLC

Timothy M. Quinn, M.D.

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?)

___Diabetes ___Obesity ___High Blood Pressure ___Heart Disease __Cholesterol

___Thyroid Cancer ___Stroke ___Osteoporosis ___Cancer ___Alcoholism

None of the Above _____

PAST SURGERIES

1. _____ **2.**_____

3. _____ **4.** _____

None of the Above _____

QUINN HEALTHCARE, PLLC

Timothy M. Quinn, M.D.

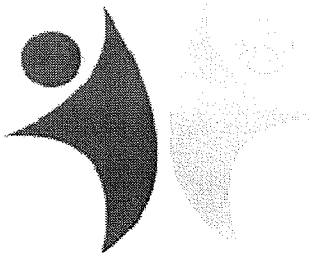
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of the **QUINN**

HEATHCARE, PLLC, Notice of Privacy Practice.

_____ _____

Signature of Patient Date



QUINN HEALTHCARE, PLLC

"Providing quality healthcare to you and your family."

Timothy M. Quinn, M.D.
768 North Avery Boulevard
Ridgeland, MS 39157

WELCOME TO QUINN HEALTHCARE

Payment -
Payment is required at the TIME OF YOUR VISIT. We accept cash, check, MasterCard or Visa. If you have insurance you MUST present the card at the time of your visit. There will be a $35.00 on all RETURNED CHECKS.

Prescriptions -
Prescriptions should be refilled before leaving the clinic. A 48 hour advance notice is required for phone-in/fax prescriptions renewals. Prescriptions will not be refilled if you miss your scheduled appointments.

Appointments -
Please notify us at least 24 hour advance if you know you need to CANCEL. If you arrive LATE for an appointment, it may be necessary to reschedule. We make every effort to run on time.

My signature indicates that I have read and understand the above agreement.

_____ _____

Patient **Date**