

Client Number: \_\_\_\_\_



**LMU - DeBusk College of Osteopathic Medicine,  
Department of Outpatient Services  
University Medical Clinic**

165 Westmoreland Street, PO Box 4408  
Harrogate, Tennessee 37752

(O) 423-869-7193

(Fax) 423-869-7195

**Client Information:**

Last Name:  MI:  First Name:  Age:

Address:

City:  State:  Zip Code:  Gender:  M  F

Email:  Marital Status:

Home #:  Cell #:  Work#:

SS#:  DOB:  Drivers License#:

Employer:

Occupation:  Job Duties:

**Emergency Contact Information:**

Spouse's name:  Contact Number:

Friend's Name:  Contact Number:

**Insurance Information:**

**Insurance Carrier #1:**  Insurance Plan:

Group #:  Policy #:  Phone #:

**Policy Holder Name:**  DOB:  SS#:

**Insurance Carrier #2:**  Insurance Plan:

Group #:  Policy #:  Phone #:

**Policy Holder Name:**  DOB:  SS#:

I hereby authorize the insurance carrier listed above to make payments directly to the Health care Provider and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan, it is my responsibility to notify the Health care Provider; otherwise I will be responsible for payment. I understand that payment is due at the time of service.

Signature:  Date: