## CLEGG, Gary JAMES (id #26931, dob: 12/14/1959)

**CLEGG, GARY 12/14/59 #26931**

* 7129714w25546 A-FormLett

**Please review and update the information below to the best of your ability.**

### Patient Registration

| CURRENT PATIENT INFORMATION -- PLEASE PRINT | Guarantor Information (to whom statements are sent) |
|---|---|
| Last Name: **CLEGG** | Name: **GARY JAMES CLEGG** |
| First Name: **GARY** | Address: **6211 JIM FOX LN** |
| Middle Name: **JAMES** | **POWELL, TN 37849-5628** |
| Address: **6211 JIM FOX LN** | Relationship to patient: _____ |
| City: **POWELL** State: **TN** | Date of Birth: **12/14/1959** |
| Zip: **37849-5628** | Social Security No.: **023547327** |
| Home Phone: **(865) 919-1690** | Phone: ( ) _____ - _____ |
| Work Phone: | **Emergency Contact Information** |
| Mobile Phone:**(865) 919-1690** | Name: **DEBI CLEGG** |
| Sex: **M** | Relationship: **SPOUSE** |
| Date of Birth: **12/14/1959** | Phone: **(865) 679-3292** |
| Social Security No.:**023547327** | Mobile Phone:( ) _____ - _____ |
| Patient email: **gclegg@mmproductionsusa.com** | |
| Required by government mandate [although you may refuse]: | **Employer information** |
| Language: **English** | Employer: |
| Race: **White** | Address: |
| Ethnicity: **Not Hispanic or Latino** | Phone: |
| Marital Status: **M** | |

| Other | Pharmacy Information: |
|---|---|
| Patient Referred by: | Name: |
| Primary Care Provider: | Crossroads: |
| Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email | Phone: |

| Primary Insurance Information | Secondary Insurance Information |
|---|---|
| Insurance Plan Name: | Insurance Plan Name: |
| Last Name: | Last Name: |
| First Name: | First Name.: |
| Middle Name: | Middle Name: |
| Address: | Address: |
| City: State: Zip: | City: State: Zip: |
| Policy #: | Policy #: |
| Policy Number: | Policy Number: |
| Date of Birth: Sex (please circle): **M** or **F** | Date of Birth: Sex (please circle): **M** or **F** |
| Employer Name: | Employer Name: |
| Patient's relationship to policy holder: | Patient's relationship to policy holder: |

**To the best of my knowledge the above information is complete and accurate.**

**Signed**_____ **Date:**_____