Date_____

11509 Hardin Valley Rd
Knoxville, TN 37932

# Primary Care of Tennesse
# Patient Registration Form

## Patient Information

First Name _____ MI ___ Last Name _____ M F

DOB _____ SSN _____ Marital Status ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Address/Apt # _____

City _____ State _____ Zip _____

Home No. Cell No.

## Emergency Contact

First Name _____ Last Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Ph No. 1 Ph No. 2

## Employer Information

Employer Name _____

Employer Address _____

City State: Zip Phone No.

## Insurance Information

Primary Insurance Name _____

Name of Policy Holder _____ DOB (if not self) _____

Relationship to Patient _____ SSN (if not self) _____

Patient's Policy ID No. _____ Policy Start Date _____

**Secondary Insurance information**

Secondary Insurance Name (if applicable): _____

Name of Policy Holder _____ DOB (if not self) _____

Relationship to Patient _____

Patient's Policy ID No. Policy Start Date

## Pharmacy Information

Pharmacy Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

**PERSONAL EMAIL** (if you want access to your online medical record): _____

Mail Order Pharmacy Name: (if applicable): _____

Address _____

City: _____ State _____ Zip _____

Ph No. Fax No.

## Authorization Information

**Race: (circle):** American Indian/Alaskan Native, Asian, Black/African American, Native Hawaiian/other Pacific Islander

**Ethnicity: (circle):** Hispanic or Latino, White

**Language: (circle):** English, Spanish, Other:_____

I hereby assign to **Primary Care of TN** any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I also understand that in the event that services rendered are not covered by my "insurance," I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I received for the services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me(depending upon the agreement) at this time.

**Signature of Patient/Legal Guardian:** Date:

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**RELEASE OF INFORMATION**

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPAA Notice of Privacy Practices" information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

**Signature of Patient/Legal Guardian:** Date