

Date _____

11509 Hardin Valley Rd
Knoxville, TN 37932

Primary Care of Tennessee 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. _____ Email Address: _____

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: _____

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 _____