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

*ADVANCED DIRECTIVE? YES NO Consent to Telehealth/Telemedicine YES NO