Patient Registration

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________ Middle Initial: ____

DOB: ____________ Sex: ☐ Female ☐ Male Social Security Number: ______________

Marital Status: ______________ Email: ______________________

Street Address: ______________________________________

City: ______________________ State: ______ Zip: __________

Home Phone: ______________________ Cell Phone: ______________________

PHARMACY NAME & PHONE NUMBER: ______________________

PRIMARY CARE PHYSICIAN: ______________ **REFERRING PHYSICIAN:** ______________

PARENT OR GUARDIAN INFORMATION *(Only fill out if the patient is under the age of 18)*

Last Name: ______________________ First Name: ______________ Middle Initial: ____

Street Address: ______________________________________

City: ______________________ State: ______ Zip: __________

DOB: ________ Social Security Number: ______________ Relationship to Patient: ______________

Home Phone: ______________________ Cell Phone: ______________________

EMERGENCY CONTACT INFORMATION

Name: ______________________________ Relationship to Patient: ______________

Home Phone: ______________________ Cell Phone: ______________________

EMPLOYER: ______________________________________

PRIMARY INSURANCE INFORMATION

Insurance Plan Name: ______________________ Subscriber ID: ______________

POLICY HOLDER NAME *(if other than patient)*: ______________________

DOB: ____________ Sex: ☐ Female ☐ Male Relationship to Patient: ______________

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: ______________________ Subscriber ID: ______________

POLICY HOLDER NAME *(if other than patient)*: ______________________

DOB: ____________ Sex: ☐ Female ☐ Male Relationship to Patient: ______________

The information below is being collected pursuant to the requirements of the TN Department of Health in compliance with Tennessee state law.

RACE: ☐ White ☐ Black ☐ American Indian ☐ Eskimo or Aleut ☐ Asian or Pacific Islander ☐ Other Race ☐ Unknown Race

ETHNICITY: ☐ Hispanic Origin ☐ Not Hispanic Origin

Please check the appropriate box in answer to the following question. Have you executed an Advanced Health Care Directive, A Living Will or a Power of Attorney? ☐ Yes ☐ No

Do you want anyone to have access to your Protected Health Information (PHI)? ☐ Yes ☐ No

If yes, who: ______________________________________

Signature: ______________________________ **Date:** __________

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