New Patient Registration

PATIENT INFORMATION

Last Name: _____ First Name: _____ M. Initial: ____

DOB: _____ Sex: ☐ Female ☐ Male Social Security Number: ____-____-____

Marital Status: _____ email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

PHARMACY NAME & PHONE NUMBER: _____

PRIMARY CARE PROVIDER: _____ **REFERRING PROVIDER:** _____

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

Last Name: _____ First Name: _____ M. Initial: ____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Social Security Number: ____-____-____

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

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 PHI? IF SO, WHO? NAME: _____

Signature: _____ **Date:** _____

Relationship to Patient: _____