East Tennessee Medical Group

A member of the Blount Memorial Physicians Group

# Patient Information Form

PLEASE PRINT CLEARLY

☐ MALE ☐ FEMALE

DATE OF BIRTH

_____/_____/_____

SOCIAL SECURITY NO.

_____________________

EMERGENCY PHONE

_____________________

Name

Address

City State Zip

Home Phone Cell Phone

Work Phone Email Address

Employer

Primary Care Physician Referring Physician

Referring Physician Address Telephone No.

Do you have insurance? ☐ YES ☐ NO Primary Insurance Company

Relationship to Policy Holder ☐ SELF ☐ SPOUSE ☐ DEPENDENT

Name of Policy Holder DOB

Employer Policy Holder Social Security No.

Secondary Insurance Company

Relationship to Policy Holder ☐ SELF ☐ SPOUSE ☐ DEPENDENT

Name of Policy Holder DOB

Employer Policy Holder Social Security No.

**MESSAGES:** May we leave a message at the contact number you indicated on your registration form regarding lab results, prescriptions, verification of appointment and/or test results?

☐ **YES** ☐ **NO**

If no, please specify a number(s) where we may contact you:

_____________________

_____________________

_____________________

**PERMISSION FOR DISCLOSURE:** I give my permission to disclose my protected health information to the following people:

Name Relationship DOB

Name Relationship DOB

Name Relationship DOB

Signature of Patient or Patient's Representative Date

Printed name of Patient's Representative

Relationship to Patient