Regional Practices

Patient Information

Patient Primary Care Physician: ______________________

Last name: ______________________ First: ______________________ Mid: __________

D.O.B.: ___ /___ /______ Sex: ☐ Male ☐ Female SSN: ______-_____-________

Siblings:____

Address Line 1: ______________________ Primary phone: ☐ Home ☐ Cell

Address Line 2: ______________________ Home phone: (____)______ - __________

City: ______________ State: ______ ZIP: __________ Cell phone: (____)______ - __________

Mother/legal guardian **Relation:** ______________________

Last name: ______________________ First: ______________________ Mid: __________

D.O.B.: ___ /___ /______ Sex: ☐ Male ☐ Female SSN: ______-_____-________ Email: ______________

Address Line 1: ______________________ Primary phone: ☐ Home ☐ Cell

Address Line 2: ______________________ Home phone: (____) ______ - __________

City: ______________ State: ______ ZIP: __________ Cell phone: (____) ______ - __________

Employer: ______________________ Ok to leave message: ☐ Y / ☐ N

Address: ______________________ Marital status: ______________

City:______________ State: ______ ZIP: __________ Work phone: (____) ______ - __________

Father/legal guardian **Relation:** ______________________

Last name: ______________________ First: ______________________ Mid: __________

D.O.B.: ___ /___ /______ Sex: ☐ Male ☐ Female SSN: ______-_____-________ Email: ______________

Address Line 1: ______________________ Primary phone: ☐ Home ☐ Cell

Address Line 2: ______________________ Home phone: (____) ______ - __________

City: ______________ State: ______ ZIP: __________ Cell phone: (____) ______ - __________

Employer: ______________________ Ok to leave message: ☐ Y / ☐ N

Address: ______________________ Marital status: ______________

City:______________ State: ______ ZIP: __________ Work phone: (____) ______ - __________

Emergency contact *(other than parent or legal guardian)* Relation: ______________________

Last name: ______________________ First: ______________________ Mid: __________

Address: ______________________ Home phone: (____) ______ - __________

City:______________ State: ______ ZIP: __________ Cell phone: (____) ______ - __________

Patient

Race: ☐ American indian/Alaska native ☐ Asian ☐ Black or African american ☐ Hispanic ☐ White ☐ Other

Ethnicity: ☐ Non-hispanic ☐ Hispanic/Latino ☐ Refused to report

Preferred language for healthcare discussion: ☐ English ☐ Spanish ☐ Other______________________

Form No. 31654 (09/16)

Insurance information *(primary)*

Insured's last name: ______________________ First: ____________________ MI: ____

Relationship to patient:____________________ D.O.B.: ___ /___ /______ SSN:_____-____-_____

Insured address:______________________________ Phone: (____)______ - __________

City:____________________ State: ______ ZIP: ____________

Insurance name:________________________________ Effective date: ___ /___ /______

Employer name:________________________________

Insurance information *(secondary)*

Insured's last name: ______________________ First: ____________________ MI: ____

Relationship to patient:____________________ D.O.B.: ___ /___ /______ SSN:_____-____-_______

Insured address:________________________________Phone: (____)______ - ________

City:____________________ State: ______ Zip: ____________

Insurance name:______________________________ Effective date: ___ /___ /______

Employer name:________________________________

Pharmacy

1) Name: ________________________________ Phone: (____)______ - _________

Address: ____

2) Name: ________________________________ Phone: (____)______ - _________

Address: ____

Preferred communications

Phone call: ☐

Text messaging: ☐

Preferred phone: (____)______ - _________

Preferred language: ☐ English ☐ Spanish

Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening

Send reminder/Follow-up letters: ☐

Send reminder/Follow-up emails: ☐

Type of reminders/Follow-up:

Select all ☐

Appointments ☐

Lab results ☐

Health maintenance ☐

Rx confirmation ☐

General notification ☐

I give consent for the individuals listed on this form to bring the patient to East Tennessee Children's Hospital for treatment of illnesses or injuries. I hereby give permission to East Tennessee Children's Hospital to exchange information with the individuals listed on this form.

______________________________ ________________ ______________

Parent/legal guardian signature Relationship Date