EAST TENNESSEE Children's Hospital

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: _____-_____-_____ Marital status: _____

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

Address Line 2: _____ Home phone: (____) _____ - _____

City: _____ State: _____ ZIP: _____ Cell phone: (____) _____ - _____

Ok to leave message: ☐ Y / ☐ N

Employer: _____

Address: _____ Email: _____

City: _____ State: _____ ZIP: _____ Work phone: (____) _____ - _____

Father/legal guardian **Relation:** _____

Last name: _____ First: _____ Mid: _____

D.O.B.: ___/___/_____ Sex: ☐ Male ☐ Female SSN: _____-_____-_____ Marital status: _____

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

Address Line 2: _____ Home phone: (____) _____ - _____

City: _____ State: _____ ZIP: _____ Cell phone: (____) _____ - _____

Ok to leave message: ☐ Y / ☐ N

Employer: _____

Address: _____ Email: _____

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 (06/16)

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:_____-____-_____

İnsured 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 ☐

_____ _____ _____

Parent/legal guardian signature Relationship Date