EAST TENNESSEE Children's Hospital

Regional Practices

Patient Information

Last name: _____ First: _____ Mid: _____

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

Primary Care Physician: _____

Siblings:_____

Email: _____

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

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

Mother/legal guardian *(For adult patients, list spouse if applicable)* **Relation:** _____

Last name: _____ First: _____ Mid: _____

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

Address: _____ Primary phone: ☐ Home ☐ Cell

Home phone: (____) _____ - _____ Cell phone: (____) _____ - _____ Ok to leave message: ☐ Y / ☐ N

City: _____ State: _____ ZIP: _____

Employer: _____

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 (01/2023)

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: ___ /___ /_____

Subscriber ID: _____

Insurance information *(secondary)*

Insured's last name: _____ First: _____ MI: ____

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

İnsured address:_____Phone: (____)_____ - _____

City:_____ State: _____ Zip: _____

Subscriber ID:_____ Effective date: ___ /___ /_____

Pharmacy

1) Name: _____ Phone: (____)_____ - _____

Address: _____

2) Name: _____ Phone: (____)_____ - _____

Address: _____

Preferred communications

Our office communicates appointment reminders, referral and prescription information and other general office updates by text message.

Text messaging: ☐

Phone call: ☐ Ok to leave a message? ☐ Yes ☐ No

Preferred mobile phone: (____)_____ - _____

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

_____ _____ _____

Parent/legal guardian signature (Patients 18 years or older, sign here) | Relationship | Date