

## PATIENT INFORMATION

Name: \_\_\_\_\_  
Last First M.I.

Complete Address: \_\_\_\_\_  
Street Apt # City State Zip

Home Phone: ( ) \_\_\_\_\_ Sex:  Male  Female

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Employer \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Is patient a full time student?  YES  NO

### PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

<b>HAVE YOU APPLIED FOR OR ARE YOU COVERED BY TENNCARE?</b>	<b>YES</b>	<b>NO</b>
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### INSURANCE COVERAGE – PRIMARY:

Insurance Co. Name: \_\_\_\_\_

Name of Policy Holder (Insured): \_\_\_\_\_

Policy Holder (Insured) Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder Social Security # \_\_\_\_\_

### INSURANCE COVERAGE – SECONDARY:

Insurance Co. Name: \_\_\_\_\_

Name of Policy Holder (Insured): \_\_\_\_\_

Policy Holder (Insured) Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder Social Security # \_\_\_\_\_

***Please present insurance and pharmacy card(s) and photo ID to the receptionist so copies may be made.***

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_