EAST TENNESSEE Children's Hospital

Patient Information

Patient

Primary Care Physician: _____

Last Name: _____ First: _____ Mid: _____

DOB: ___ /___ /_____ 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: _____

DOB: ___ /___ /_____ Sex: Male/Female SSN: _____-_____-_____ Email: _____

Address: _____ Primary Phone: ❒ Home ❒ Cell

City:_____ State: _____ Zip: _____ Home Phone: (____)_____ - _____

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: _____

DOB: ___ /___ /_____ Sex: Male/Female SSN: _____-_____-_____ Email: _____

Address: _____ Primary Phone: ❒ Home ❒ Cell

City:_____ State: _____ Zip: _____ Home Phone: (____)_____ - _____

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: (____)_____ - _____

(Continued on back)

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_____

Insurance Information (Primary)

Insured's Last Name: _____ First: _____ MI: _____

Relationship to Patient:_____ DOB: ___/___/_____ 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:_____ DOB: ___/___/_____ 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: ❒

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 ETCH for treatment of illnesses or injuries. I hereby give permission to ETCH to exchange information with the individuals listed on this form.

_____ _____ _____

Parent/Legal Guardian Signature **Relationship** **Date:**