Date: _____ Chart #: _____

OB/GYN PROFESSIONALS OF EAST TENNESSEE, P.C.

PATIENT INFORMATION (Only dark blue or black ink will be accepted)

PERSONAL INFORMATION

Patient Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Marital Status: _____ Married _____ Single

Address: _____ City: _____ State: _____ ZIP: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

SS#: _____ Employer: _____

Spouse/Parent Name: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Address: _____ City: _____ State: _____ ZIP: _____

Who is your family doctor? _____ Ph: _____

Pharmacy Name: _____ Location: _____ Ph: _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Whose name is the primary insurance in? _____

Who is subscriber? Self: _____ Spouse: _____ Parent: _____

Subscriber DOB: _____ Subscriber SS#: _____

Whose name is the secondary insurance in? _____

Who is subscriber? Self: _____ Spouse: _____ Parent: _____

Subscriber DOB: _____ Subscriber SS#: _____

It is required that we have the SS# and DOB of the primary subscriber for the insurance for billing purposes. Without it, we will be unable to send out specimens to the laboratory.

NEXT OF KIN INFORMATION

Name of next of kin: _____ Relationship: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Address: _____ City: _____ State: _____ ZIP: _____

Signature: _____ Date: _____