Rev. 2/20

Cardiology Associates of East Tennessee

9320 Parkwest Blvd., Knoxville, TN 37923

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):	SSN#	Birthdate	Age	Sex

Mailing Address	City, State, Zip

Home Phone	Cell Phone	Email Address

Marital Status	Student Status	Smoker?	Veteran (Y/N)?	Ethnicity: Hispanic or	Primary Care Physician
	☐Full-Time ☐Part-Time	Yes or No		Non-Hispanic	

Referring Physician	Referring Physician Contact #	Other Medical Providers

Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White

Language: _____

Emergency Contact Name	Emergency Contact Phone #s
	Hm: Cell:

Employer Name and Address	Work Phone #

How did you learn about our office? Please circle one. Billboard Ad Direct Mail Hospital Referral Insurance Newspaper Ad Patient Referral Physician Referral Previous Patient Internet Self-Referral Yellow Pages Other:

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s
	Hm: Wk: Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle)	SSN#	Birthdate	Sex

Address	City, State, Zip

Home Phone	Cell Phone	Work Phone	Relationship to patient

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	**Insured's SSN #**	**Insured's Insurance ID #**	**Relationship to patient**

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	**Insured's SSN#**	**Insured's Insurance ID #**	**Relationship to patient**

WORKERS COMPENSATION

Are you here for workers compensation YES_____NO_____ Date:

ACCIDENT

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) ☐ Yes ☐ No

Do you have a Power of Attorney? ☐ Yes ☐ No

If yes to the above questions please make sure we have a copy for your medical record.

SHARING YOUR INFORMATION

In the event our office needs to contact you regarding your appointment, etc.

I give permission to be contacted by phone/text and for messages to be left at this number.

☐ Yes (☐ Cell ☐ Home ☐ Work) ☐ No

I give permission to have letters, documents and postcards sent to my home and or patient portal account.

☐ Yes ☐ No