East Tennessee Medical Associates, P.C.
Patient Registration
(Please Print)

Record #_____ Physician: _____ Date of Registration: _____

Patient's Name: _____ / ____ / ____
Last First Middle Age Date of Birth

Address: _____
Street City State Zip Code

Sex: M_____ F _____ Marital Status: _____ Home Phone: _____ Cell: _____

Social Security #: _____ Ethnicity: _____ Race: _____

Preferred Language (Check one): English_____ Spanish_____ Other (Please Specify)_____

Email address: _____ **Employer:** _____

Primary Care Physician: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Insurance Information

Primary Insurance:

Insurance Carrier: _____ **ID#:** _____ **Group#** _____

Insurance Claims Address: _____ **Phone:** _____

*** Complete the following information ONLY if different from Patient:**

*Name of Insured: _____ / ____ / _____
Last First Middle Date of Birth Relationship to Patient

*Address: _____
Street City State Zip Code

*Insured's Social Security #: _____ Home Phone: _____ Work Phone: _____

*Insured's Employer: _____ Employer's Address: _____

Secondary Insurance (Complete ONLY if applicable):

Name of Insured: _____ / ____ / _____
Last First Middle Date of Birth Relationship to Patient

Address: _____
Street City State Zip Code

Insured's Social Security #: _____ Home Phone: _____ Work Phone: _____

Insured's Employer: _____ Employer's Address: _____

Insurance Carrier: _____ ID#: _____ Group# _____

Insurance Claims Address: _____ Phone: _____

*****Signature of Consent for Treatment /Parent or Guardian if patient is a minor*****

_____ / _____ / _____ / _____
Signature Relationship (Print Name) Date

East Tennessee Medical Associates, P.C. **Chart #_____**

Acknowledgment of Receipt of Notice of Privacy Practices

I have been provided with a copy of the Notice of Privacy Practices from East Tennessee Medical Associates, P.C., detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

_____ _____
Patient's Signature Date

Patient Authorization Regarding Contact Methods

We want to know how to get medical information to you if we are unsuccessful in reaching you at your primary contact phone number. By placing your initials in the spaces below you give your authorization to have your health information relayed to you as follows:

_____ You may contact me at work. The phone number is: (____) _____-_____
Initial

_____ You may leave messages on my voice mail at: (____) _____-_____
Initial

_____ You may call me on my cell phone. The number is: (____) _____-_____
Initial

You may leave messages with my spouse, and/or relative(s) , and/or friend(s) listed below:

_____ (____) _____ _____
Name of Person Phone Number Relationship to Patient

_____ (____) _____ _____
Name of Person Phone Number Relationship to Patient

_____ (____) _____ _____
Name of Person Phone Number Relationship to Patient

East Tennessee Medical Associates, P.C.
107 Woodlawn Drive, Suite 200
Johnson City, TN 38604
(423) 929-7158

Financial Policy

If you have insurance, we will be glad to file the claim for you. It is the responsibility of the patient to provide complete and accurate insurance information. We will allow 30 days for your insurance company to process your claim. If you have an office visit co-pay, it is due at the time of service. This is usually indicated on your insurance card. Once your insurance company processes your claim any amount applied to your deductible or any remaining balance (patient responsibility) will be billed to you.

If you do not have insurance coverage, payment is due at the time of service.

Lab services are provided by **LabCorp.** Any lab work you have while you are here will be filed to your insurance company by **LabCorp** or billed to you by **LabCorp** if you do not have insurance coverage.

Please sign below indicating you understand the above financial policy. If you have any questions regarding this policy, please do not hesitate to ask.

_____ _____

Signature of Patient or Responsible Party **Date**

Easily manage your health & wellness online, anytime.

FollowMyHealth™

Universal Health Record

Sign up for these benefits:

- 24/7 Access to lab and test results
- Secure private messaging to communicate with your doctor
- Appointment scheduling without the hassle of calling
- Rx Refill Requests

To receive an invitation to use Follow My Health simply complete the following information and return it with your new patient paperwork.

Name:_____

DOB:_____

Email Address:_____

PERSONAL MEDICATION RECORD

Complete the information and bring it with you when you come for your appointment. Thank you!

Date: **Name:**

Height: **Weight:**

List all prescription medications, over-the-counter medications, vitamins and herbal supplements that you are taking. List all prescribing phsycians. At the end, please answer the questions dealing with what you are allergic to. Thank you!

Medication	**Physician** (last name, first name)	**Strength** (of med eg., 10 mg)	**Time**	**Time**	**Time**	**Time**	**Time**	**Total Strength for this medication**	**Reason for taking this medication?**

This tool is provided by the Medical Group Management Association (MGMA).