Sewanee Pediatric and Adolescent Medicine 18 years and older

Patient Registration

Patient Name ____
Last First Middle Preferred Name

Birthdate: ____________ Social Security#: ____________ Gender: ____________
Male/Female

Mailing Address: ____________________ City/State/ Zip ____________________

Patient phone/cell: ____________________

Mother's Name: ____________________ DOB: ____________ Phone: ____________

Father's Name: ____________________ DOB: ____________ Phone: ____________

Preferred Email address: ____________ Preferred Contact Method: Home phone/Cell phone/Text /Email

We will make every effort to contact you to confirm your appointment, if you do not confirm we have the right to schedule another appointment in your allotted time and you may be asked to reschedule. If your appointment is not cancelled or rescheduled following our cancellation policy guidelines you will be charged a $20 missed appointment fee. It is your responsibility to make sure that we have your correct phone number.

Preferred Pharmacy: ____
Name Location

Race: (Circle One) American Indian/Alaskan Native, Asian, Black/African American, Nat Hawaiian/Pacific Islander, White Declined, Other ____________

Ethnicity: (Circle One) Hispanic or Latino, Not Hispanic or Latino, Declined

Preferred Language: English, Spanish, or Other ____________

Copays and balances will be due date of service. You will be responsible for copays and balances. Any copay not paid on date of service will be charged a $10 late copay fee. We require a credit card to be kept on file.

Emergency Contact: ____________ Relationship ____________ Phone ____________

Primary Insurance: Must have a copy. If we do not have correct information including secondary, you could be responsible for any balances this may generate.

Name of Person Carrying Insurance: ____________________ DOB: ____________

Insurance Company: ____________________ Employer: ____________

Policy Number: ____________________ Group Number: ____________

Person Carrying Insurance Social Sec # : ____________________

Secondary Insurance: Must have a copy.

Name of Person Carrying Insurance: ____________________ DOB: ____________

Insurance Company: ____________________ Employer: ____________

Policy Number: ____________________ Group Number: ____________

OVER

Person Carrying Insurance Social Sec # : ____________________

List other family members living in the household, name and relationship.

1) ____________________ 2) ____________________

3) ____________________ 4) ____________________

You will be responsible for charges incurred on the day of service including copays. If your parent is responsible, they must send copays on date of service or call and pay copay or balances prior to or on date of service.

We have providers on call 24/7, please call our office prior to going to urgent care.

Notice of Deemed Consent of HIV testing:

Pursuant of TN Law, if any staff member is exposed to blood or bodily fluid from me, I give consent to be tested for HIV.

Signature: ____________________ Date: ____________________

Authorization and release, Assignment of Benefits

I hereby authorize you to release any written, and/or verbal information regarding the treatment to third party payors. I authorize my insurance company to pay benefits directly to Sewanee Pediatrics. I agree to be responsible for all services rendered, not covered by my insurance carrier and any associated collection fees.

I hereby authorize Sewanee Pediatrics and their Physician Extenders to conduct and direct medical care. I also authorize Sewanee Pediatrics staff, directed by the Physician, to give medications, perform diagnostic procedures and provide other care which, in the judgement of the physician, is required for my best care and treatment.

Signature____________________ Date____________________