

UNIVERSITY HEALTH SERVICES
615 McCallie Avenue, Department 6856
Chattanooga, TN 37403
423-425-4453 (o) 423-425-2266 (f)

PATIENT INFORMATION:

First _____ Middle I. _____ Last _____

Address: _____

City _____ State: _____ Zip: _____

County: _____ Race: _____

Phone #: _____ Cell: _____

SS#: _____ Gender: _____

Date of Birth: _____ Marital Status _____

Email: _____ UTC ID _____

PATIENT EMPLOYMENT INFORMATION

Employer: _____

Employer Address: _____

Employer Phone: _____

PRIMARY INSURANCE INFORMATION:

Insurance Co. Name _____

Phone #: _____

Insured Name: _____ DOB: _____

Insured SSN: _____ Gender: _____

Policy Number: _____ Group# _____

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

Whom may we contact in case of an emergency?

_____ Relation? _____

Phone #: _____

Nearest relative NOT living with you?

_____ Relation? _____

Phone #: _____

RESPONSIBLE PARTY IF PATIENT IS A MINOR

Full Name: _____

Employer: _____

Employer Phone: _____

SS#: _____ DOB: _____

Cell #: _____

SECONDARY INSURANCE INFORMATION:

Insurance Co. Name _____

Phone #: _____

Insured Name: _____ DOB: _____

Insured SSN: _____ Gender: _____

Policy Number: _____ Group# _____

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

I have read all the information on this sheet and have completed this. I certify this information is true and correct to the best of my knowledge. I will notify the practice of any changes in my status or the above information.

PATIENT/RESPONSIBLE PARTY: _____

DATE: _____