Covenant Health Convenient Care-Downtown

418 South Gay Street, Suite 103,Knoxville, TN 37902
Main Phone 865 525-4520
Fax 865-525-4920

Date: _____

PATIENT INFORMATION

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

Mailing Address	City, State, Zip

Home Phone	Cell Phone	Email Address

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

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PATIENT INFORMATION

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Mailing Address				City, State, Zip			
Home Phone		Cell Phone		Email Address			
Marital Status	Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician		
Referring Physician		Referring Physician Contact #		Other Medical Providers			
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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.