LECONTE WOMEN'S HEALTHCARE
Covenant HEALTH

We Would Like to Thank You for Choosing
Leconte Women's Healthcare
for Your Health Care Needs.

PATIENT REGISTRATION

Last Name:	First Name:	MI:	Patient ID:
Nickname:	Maiden Name:		Race/Ethnicity: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined
Date of Birth:	Social Security:		Preferred Language:
Residential Address:			
City:	State:	Zip:	Preferred Phone: ☐ Home ☐ Cell
			Home Phone: ( ) -
Billing Address Different? Yes No			OK to leave voicemail? ☐ yes ☐ no
			Cell Phone: ( ) -
Spouse Name:	Employer:		OK to leave voicemail? ☐ yes ☐ no
			Work Phone:

OK to receive text messages for appointment reminders and other health-realated info? [ ] yes [ ] no
OK to receive e-mails for appointment reminders and other health-related info? [ ] yes [ ]no
Email address: _____@ _____
OK to receive communication through patient portal? [ ] yes [ ] no

EMERGENCY CONTACT / RELEASE OF INFORMATION:

Emergency Contact:	Relationship to Patient:	Phone Number:
May we speak to the person above about your medical care and billing?		[ ] yes [ ] no
Emergency Contact *(not living with you)*:	Relationship to Patient:	Phone Number:
May we speak to the person above about your medical care and billing?		[ ] yes [ ] no

INSURANCE INFORMATION

Primary Insurance:	Policyholder's Name:	
Relationship to Patient: *[ ]Self [ ]Spouse [ ]Child/Parent [ ]Other*	Policyholder's Social Security No:	
Member ID#:	Group #	Policyholder's Date of Birth:

Secondary Insurance:	Policyholder's Name:	
Relationship to Patient: *[ ]Self [ ]Spouse [ ]Child/Parent [ ]Other*	Policyholder's Social Security No:	
Member ID#:	Group #	Policyholder's Date of Birth:

TURN OVER

I understand this office may need to disclose my protected healthcare and personal information to another entity (referring doctors, primary-care doctors, pharmacies, my insurance company) and I consent to disclosure for these permitted uses, by fax or telephone.

Referring Doctor:	_____	**Phone:**	_____
Primary Care Doctor:	_____	**Phone:**	_____

Security Advisement: I understand that email and text messaging are not secure forms of communication and informaiton in emails or text messages can be intercepted, accessed, or used by unauthorixzed third parties. I further understand that a wireless carrier may charge for text messages and that these messages may come from an automated dialing system.

Opt Out and Number Changes: I understand that I may revoke this consent at any time by contacting 865-908-9888. I further agree that in the event this cell phone number or cell provider changes, I will inform this office.

PATIENT & GUEST AGREEMENT:
NO FOOD OR DRINKS are to be brought into our waiting rooms or exam rooms. Please eat or drink all food items before entering our suite.

Due to **LIMITED SPACE** in our office we can only allow **2 people**, including children, back with you during your appointment. (Rules may change at any time; especially during pandemic)

CELL PHONES: Please TURN OFF/SILENCE all cell phones while in our office. NO PHOTOGRAPHS are to be taken out of respect for the privacy of other patients.

PAYMENT: I hearby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described, realizing I am responsible to pay non-covered services. I understand that if my account is turned over to a collection agency, I will be responsible for any applicable fees. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

I have read the agreements above and understand. I can ask for and receive a copy of this notice for my records.

Patient Signature: _____ Date: _____

Signature of Guardian _____ Date: _____
If patient is a minor

Revised 4/4/2022