

East Tennessee Pediatric Cardiology, PC
2001 Highland Ave, Suite B
Knoxville, TN 37916
Ph: 865-971-6897
Fax: 865-971-6817

Patient Name: _____ Date of birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone#: _____ Social Security #: _____
Place of employment: _____
Work phone#: _____ Cell#: _____

Spouse/Durable medical power of attorney:

Name: _____ Date of birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone#: _____ Social Security #: _____
Place of employment: _____
Work phone#: _____ Cell#: _____

(circle): Married/Divorced/Separated/Single

Person to contact in case of an emergency (other than spouse):

Name: _____ Relationship: _____ Phone#: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____
Policy Holder: _____ Policy Holder: _____
SSN: _____ SSN: _____
Primary Care Physician: _____ PCP Phone# _____

I request payment of insurance benefits to be made on my behalf to East Tennessee Pediatric Cardiology, PC for any services rendered to me by the physician.

I authorize the release of any medical or other information to the insurance company for the purpose of determining benefits payable for related services.

I give permission to leave appointment messages on my phone: (circle) Yes/No

Patient/Durable medical power of attorney:

Signature: _____ Date: _____

These authorizations will remain valid unless retracted in writing to East Tennessee Pediatric Cardiology, PC