EAST TN PEDIATRIC CARDIOLOGY, PC 2001 LAUREL AVE, NG4, KNOXVILLE, TN37916 (865)971-6897

www.ETPC-hearts.com

Patient's Full Name:_____ Date of Birth:_____

Patient's Social Security #:_____(Needed for insurance purposes)

Address:_____Phone#:_____

City, State, Zip Code:_____

EMAIL ADDRESS(to send ETPC announcements to you):_____

Name of the Doctor that referred you to us (*NOT GROUP NAME*): _____

MY PREFERRED PHARMACY IS_____LOCATION_____

PHONE#:_____ FAX#: _____

Parent/Legal Guardian:

(circle) Mother/Father/Other- please specify

Name:_____

Parent's Soc Security#:_____

Parent's Date of Birth:_____

Address:_____

City,State,Zip:_____

Phone:_____Cell:_____

Employer:_____

(circle) Mother/Father/Other- please specify

Name:_____

Parent's Soc Security#:_____

Parent's Date of Birth:_____

Address:_____

City,State,Zip:_____

Phone:_____Cell:_____

Employer:_____

Are Parents: (please circle) Married Divorced Separated Never Married

Who is financially responsible for child? _____

Emergency Contact Person (**other than parent/guardian**):

Name:_____Relationship:_____Phone#:_____

Insurance Information: (Must be completed to file your insurance claim.)

Primary Insurance Policy Holder's Name & Birth date: _____

Secondary Insurance Policy Holder's Name & Birth date: _____

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.

Parent/Guardian Signature:_____ Date:_____

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