FamilyCare Specialists, P.C. ™

Comprehensive Healthcare With A Caring Touch.

1300 Old Weisgarber Road
Knoxville, TN 37909
Office: (865) 584-2146
Fax: (865) 584-9660

Date: _____

PATIENT INFORMATION

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

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		

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

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.