

**TENNESSEE ENDOSCOPY CENTER  
PATIENT REGISTRATION FORM**

**CHART#**

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**DATE                      PATIENT'S FIRST NAME                      MI                      LAST NAME**

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**DATE OF BIRTH              AGE      MARITAL STATUS              SEX                      SOCIAL SECURITY#**

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**ADDRESS - STREET/PO BOX                                      CITY                      STATE                      ZIP**

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**HOME PHONE#                                      WORK/BUSINESS PHONE#                                      CELL PHONE#**

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**PATIENT'S EMPLOYER'S NAME**

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**SPOUSE'S FIRST NAME                      MI                      LAST NAME                      SPOUSE'S DATE OF BIRTH**

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**SPOUSE SOCIAL SECURITY #                      WORK/BUSINESS PHONE#                                      CELL PHONE#**

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**SPOUSE'S EMPLOYER'S NAME**

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**EMERGENCY CONTACT (NOT WITHIN SAME HOUSEHOLD)**

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**NAME                                      HOME PHONE                      WORK/BUSINESS PHONE                      RELATION TO PATIENT**

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**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

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**INSURANCE NAME                                      INSURANCE NAME**

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**SUBSCRIBER NAME                                      SUBSCRIBER NAME**

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**SUBSCRIBER DATE OF BIRTH      SUBSCRIBER SS#                      SUBSCRIBER DATE OF BIRTH      SUBSCRIBER SS#**

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**DO YOU HAVE A LIVING WILL? YES \_\_\_ NO \_\_\_**

**DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE? YES \_\_\_ NO \_\_\_**

IF YES, PLEASE PROVIDE A COPY OF THE ABOVE DOCUMENT(S) TO THE OFFICE FOR YOUR MEDICAL RECORD.

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**THIS CENTER DOES NOT HONOR ADVANCE DIRECTIVES**

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If you would like a copy of your Tennessee Endoscopy notes to go to another doctor (if a doctor referred you to our office, please list that doctor also), please indicate that doctor's name and address:

REFERRING DOCTOR: \_\_\_\_\_ FAMILY DOCTOR: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE LIST ANY KNOWN ALLERGIES (TO MEDICINE OR LATEX):** \_\_\_\_\_

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