BLOUNT GASTROENTEROLOGY ASSOCIATES, PC
PATIENT REGISTRATION FORM

CHART#

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

DATE OF BIRTH	**AGE**	**MARITAL STATUS** (circle one) Single Married Divorced Widowed	**GENDER** Male / Female	**U.S. SOCIAL SECURITY#**

RACE / ETHNICITY (circle one) Caucasian – African American – Hispanic – American Indian – Asian – Other: _____

(OPTIONAL) **GENDER IDENTITY** (circle one) M – F – FTM (Transgender Male) – MTF (Transgender Female) – Other: _____

(OPTIONAL) **SEXUAL ORIENTATION** (circle one) Straight – Gay – Lesbian – Bisexual – Unknown – Other: _____

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

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

PATIENT'S EMPLOYER'S NAME	**PATIENT EMAIL ADDRESS**

HOW DO YOU PREFER TO BE CONTACTED? PLEASE CHECK ALL THAT APPLY:

_____ **HOME PHONE** _____ **WORK/BUSINESS PHONE** _____ **CELL PHONE** _____ **EMAIL**

SPOUSE'S NAME / CONTACT PHONE# / EMPLOYER (IF MARRIED)

EMERGENCY CONTACT (NOT WITHIN SAME HOUSEHOLD)

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

INSURANCE INFORMATION

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
INSURANCE NAME		**INSURANCE NAME**	
SUBSCRIBER NAME / RELATIONSHIP TO PATIENT		**SUBSCRIBER NAME / RELATIONSHIP TO PATIENT**	
SUBSCRIBER DATE OF BIRTH	**SUBSCRIBER SS#**	**SUBSCRIBER DATE OF BIRTH**	**SUBSCRIBER SS#**

***NOTE: IF YOU PROVIDE INCORRECT INSURANCE INFORMATION & DO NOT UPDATE WITHIN 90 DAYS WE WILL NOT REFILE TO ANOTHER INSURANCE COMPANY ---- AFTER 90 DAYS YOU WILL BE RESPONSIBLE FOR ALL CHARGES*

DO YOU HAVE A LIVING WILL? YES___ NO___

WOULD YOU LIKE INFORMATION ON LIVING WILLS? 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.

If you would like a copy of your Blount Gastroenterology/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:_____

_____ _____

_____ _____

HOW DID YOU HEAR ABOUT US? ___WEB SEARCH ___ADVERTISEMENT ___PHYSICIAN ___YELLOW PAGES ___ FAMILY ___FRIEND ___OTHER (EXPLAIN): _____

PLEASE LIST ANY KNOWN ALLERGIES (TO MEDICINE OR LATEX):_____

_____