

APPOINTMENT:

Date: _____

Time: _____

Chart #: _____

Acct #: _____

PHYSICIAN'S NAME: Dr. William S. Reid, Jr. Dr. Lowell D. Stanley, Jr.**OFFICE :** UT - Medical Bldg. C, Suite 280 MARYVILLE**PATIENT INFORMATION:**

NAME			SSN	
ADDRESS			SEX: Male Female	
CITY		STATE	ZIP	DATE OF BIRTH
HOME PHONE:	MARRIED SINGLE OTHER: _____		AGE	STUDENT?
EMAIL ADDRESS:				
NAME OF PHYSICIAN WHO REFERRED YOU HERE			NAME OF FAMILY PHYSICIAN	
EMPLOYER'S NAME, ADDRESS AND PHONE NUMBER _____				
PLEASE PROVIDE THE NAME, ADDRESS AND PHONE NUMBER OF SOMEONE WHO DOES NOT LIVE WITH YOU WHO WE MAY NOTIFY IN CASE OF EMERGENCY: _____				

INSURANCE INFORMATION:

INSURANCE COMPANY NAME & ADDRESS	ID NUMBER	GROUP #	POLICY HOLDER'S NAME
1			
2			
3			

PLEASE PROVIDE THE EMPLOYEE NAME, ADDRESS, DATE OF BIRTH, SOCIAL SECURITY NUMBER AND EMPLOYER OF THE POLICY HOLDER IF NOT THE PATIENT

ACCIDENT INFORMATION:

Is your illness the result of an accident? ___ yes ___ no

If yes, what type of accident?

___ Automobile ___ Work

___ Other

PRIVACY NOTICE:

I have been given the opportunity to review the Notice of Privacy Practices for Drs. Reid and Stanley.

Signature of Patient or Legal Guardian