THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

UT RHEUMATOLOGY
A Department of the University of Tennessee Medical Center
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865-305-6543 (Phone) | 865-305-2694 (Fax)
UTRheumatology@utmck.edu

PATIENT REGISTRATION

PATIENT INFORMATION				
Social Security #			**Preferred Name:**	
First Name	**MI**	**Last Name**		
Gender (Circle as many as are appropriate)				
Birth Sex: Male Female Transgender Other				
Current Sex: Male Female Transgender Other				
Date of Birth				
Preferred Language	**Race**		**Ethnicity**	
Marital Status (Circle One) Married Single Divorced Widowed				
Home Address				
City	**State**		**Zip**	
Home Phone ( )	**Work Phone** ( )		**Cell** ( )	
Email Address				
Primary Care Physician				
Employment Status (Circle One): Employed Retired Disabled F/T Student Other				
Employer:				

SPOUSE/GUARANTOR/RESPONSIBLE PARTY			
Social Security #	Sex	Date Of Birth	
Relationship	Daytime Phone ( )		
First Name	MI	Last Name	
Address	City	State	Zip
Employer	Address		
City	State	Zip	

EMERGENCY CONTACT			
Relationship	Date of Birth		
First Name	MI	Last	
Home Phone ( )	Cell Phone ( )	Work Phone ( )	

PRIMARY INSURANCE INFORMATION		
******PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST******		
Insurance	ID #	GR #
Name of Insured	DOB	SS#

SECONDARY INSURANCE INFORMATION		
Insurance	ID#	GR #
Name of the Insured	DOB	SS#

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent if Minor)	**DATE**

PLEASE SEE OTHER SIDE FOR MORE INFORMATION → → →