

BLOUNT GASTROENTEROLOGY ASSOCIATES, PC  
 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 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: \_\_\_\_\_

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

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