

## Patient Registration

Date \_\_\_\_\_ Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Preferred phone: \_\_\_\_\_ ( ) cell ( ) home ( ) work ( ) other

OK to leave detailed messages on this phone? ( ) yes ( ) no

Other phone: \_\_\_\_\_ ( ) cell ( ) home ( ) work ( ) other

OK to leave detailed messages on this phone? ( ) yes ( ) no

Appointment reminders by: ( ) phone \_\_\_\_\_ and/or email ( ) \_\_\_\_\_

Mailing address: \_\_\_\_\_

Street address, if different: \_\_\_\_\_

Age \_\_\_\_ Date of Birth \_\_\_\_\_ Referred by: \_\_\_\_\_

Address & Phone of referrer, if another provider: \_\_\_\_\_

Current therapist, if not referrer: \_\_\_\_\_ Therapist phone \_\_\_\_\_

Primary care provider: \_\_\_\_\_ PCP phone \_\_\_\_\_

PCP Address: \_\_\_\_\_

Pharmacy used, if applicable: \_\_\_\_\_ Pharmacy phone: \_\_\_\_\_

Patient employer: \_\_\_\_\_

Emergency contact (relationship & phone): \_\_\_\_\_

Person responsible for payment, if other than patient (please give address & phone):

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### Insurance Verification Acknowledgement (if applicable)

I certify that the insurance information I provided is correct. I authorize the release of any information regarding my evaluation or treatment necessary to process the insurance claim. I authorize the release of pertinent information required by my Managed Care company for treatment plans and summaries. I authorize the payment of benefits to the provider for services provided.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Access Psychiatry

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