East Tennessee Children's Hospital
Gastroenterology and Nutrition Services
Medical Office Building
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Patient Information

Date _____

Last Name _____

First Name _____ Middle _____

Sex _____ Date of Birth _____ SS# _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone (area code) ( ) _____

Race: ___ Asian ___Biracial ___American Indian or Alaska Native ___Native Hawaiian or Other Pacific Islander ___White ___Black or African American ___Other: _____ ___Prefer not to answer

Ethnicity: ___ Hispanic ___ Non-Hispanic

Preferred Language for Healthcare Discussion _____

Physician Information

Referring Doctor _____

Reason for Visit _____

Primary Care Doctor _____

Phone ( ) _____

Mother/Guardian Information

Last Name _____

First Name _____ Middle _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone (area code) ( ) _____

Cell Phone ( ) _____

Work Phone (area code) ( ) _____

SS# _____ DOB _____

Employer _____

Email Address _____

Marital Status *(Check one of the following)*

____ Single ___Married ____Divorced ___Widowed ___ Separated

Emergency Contact

Please list the name of a relative or friend that does not live with you and can be contacted in case of an emergency.

Name _____

Relationship to Patient _____

Phone (area code) ( ) _____

Insurance

Primary Insurance Company _____

Who carries the insurance on the patient?

Mom _____ Dad _____ Guardian _____ DOB _____

Name _____

Effective date: _____

Secondary Insurance Company _____

Who carries the insurance on the patient?

Mom _____ Dad _____ Guardian _____

Name _____

Effective date _____

Father/Guardian Information

Last Name _____

First Name _____ Middle _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone (area code) ( ) _____

Cell Phone ( ) _____

Work Phone (area code) ( ) _____

SS# _____ DOB _____

Employer _____

Email Address _____

Marital Status *(Check one of the following)*

____ Single ___ Married ___ Divorced ___Widowed ___Separated

Agreement and Consent

I hereby give consent for the following individuals to bring my child to GI For Kids, PLLC, for treatment and to exchange necessary information with GI For Kids, PLLC. This request will remain in effect until revoked by me in writing.

_____ / _____

_____ / _____

Patient's Name _____

Signature of Parent/Legal Guardian _____

Relationship to Patient _____ Date _____

PLEASE COMPLETE REVERSE SIDE

1. I am the parent or legal guardian authorized to act on the patient's behalf. I hereby authorize medical services to be provided to the patient by the MDs, mid level providers, dieticians, clinical psychologists and medical staff of GI For Kids, PLLC as necessary.

2. Acknowledgement of Receipt of Privacy Notice: I acknowledge receiving upon request, a copy of the provider's notice of privacy policies. I consent to the provider's use of protected health information as described in the notice of treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

3. Referrals: I understand that if the patient's insurance plan requires a referral from the primary care physician, the referral must be obtained prior to the visit in order to ensure the patient's maximum benefit from the insurance plan. I further understand if the referral is not in place, I agree to sign a waiver taking full responsibility for payment due for services rendered by GI For Kids, PLLC.

4. I understand that all services may not be covered by the patient's insurance plan. I understand that I am responsible to pay for all services rendered not covered by the patient's insurance. I understand that any unpaid account balance owed to GI For Kids, PLLC by me, may be turned over to a collection agency that will include collection agency fees and may affect my credit rating.

5. I hereby authorize GI For Kids, PLLC, to release information to referring MDs, insurance companies, government agencies, etc., as necessary, in order for GI For Kids, PLLC to obtain payment for services rendered.

6. I authorize and request payment to be made directly to GI For Kids, PLLC for insurance benefits payable for services provided by GI For Kids, PLLC. This authorization expressly includes benefits that are provided by TennCare and/or any other public or private insurance plan.

7. Reminder/Notification: I grant GI For Kids, PLLC, permission to leave a message regarding appointments, discussion of treatment plan, etc. at the phone numbers I listed on the registration form.

8. I grant permission for the patient's photo to be taken and retained in his/her personal medical chart or file for identification purposes only.

Patient's Name _____

Signature of Parent/Legal Guardian _____

Relationship to Patient _____

Date _____