Family Clinic of Oak Ridge
100 Vermont Avenue
Oak Ridge, TN 37830

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):				SSN#	Birthdate	Age	Sex
Mailing Address				City, State, Zip			
Home Phone		Cell Phone		Email Address			
Marital Status	Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician		
Referring Physician		Referring Physician Contact #	Other Medical Providers				
Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White					Language		
Emergency Contact Name		Emergency Contact Phone #s Hm:		Cell:			
Employer Name and Address					Work Phone #		

How did you learn about our office? Please circle one. Billboard Ad Direct Mail Hospital Referral Insurance Newspaper Ad Patient Referral Physician Referral Previous Patient Internet Self-Referral Yellow Pages Other:

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm:	Wk:	Cell:

I am the legal guardian and give Family Clinic Oak Ridge permission to treat my child in my absence YES NO

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle			SSN#	Birthdate	Sex
Address			City, State, Zip		
Home Phone	Cell Phone	Work Phone	Relationship to patient		

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation

Are you here for workers compensation YES_____NO_____ Date of Incident:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____

Do you have a Power of Attorney? Yes_____ No_____

If yes to the above questions please make sure we have a copy for your medical record.