

PRODIGAL PRIMARY CARE

10904 Kingston Pike
Knoxville, TN 37934
(865) 288-3754

Patient Info Sheet: Please Print

Name: _____ DOB: ____/____/____
Address: _____ Sex: M or F Age: _____

Marital Status: S M D W Sep
City: _____ State: _____ ZIP: _____ SS#: _____
Home Phone: _____ Cell Phone: _____
Driver's License #: _____ State: _____ Expiration Date: ____/____/____

Emergency Contact Information (anyone you want to have access to your records):

Name: _____ Phone #: _____ Relation: _____
Name: _____ Phone #: _____ Relation: _____

Primary Insurance Information

Insurance Company: _____
Policy/ ID #: _____
Group #: _____
Policy Holder: _____
Relation to Policy Holder: _____

Secondary Insurance Information

Insurance Co: _____
Policy/ ID#: _____
Group #: _____
Policy Holder: _____
Relation to Policy Holder: _____

I, _____ agree to the payment terms set forth by Prodigal Primary Care, and acknowledge that I will be personally responsible for any fees or charges related to my care that are deemed non-covered or non-payable by my insurance company.

Self Pay: I agree that I will be responsible for payment in-full at the time of service.

Patient Signature: _____ Date: _____