

# 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: \_\_\_\_\_