Print Form

Personal Choice Health Care Service PC

P O Box 30794
Knoxville, TN 37930-0794
(865) 692-1400

PATIENT INFORMATION

NAME (Last, First Middle)			SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)			SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	$
CITY, STATE ZIP	PHONE	DEDUCTIBLE	$
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	$
CITY, STATE ZIP	PHONE	DEDUCTIBLE	$
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I agree the above information is correct and I understand any amount not paid by my insurance company is my responsibility. I also understand if I have not provided the correct insurance information I will be responsible for my balance in full. I authorize the release of medical information to my insurance company and it's agents for the determination of benefits for the services rendered. I also understand that I am responsible for any copays, coinsurances, deductables or any amounts the insurance company does not pay. I agree to be responsible for any and all collection fees should my account become delinquent. I authorize Medicare and/or my insurance company _____ to release payment owed for services rendered to Personal Choice HealthCare P.C. on my behalf.

SIGNATURE OF PATIENT/GUARDIAN

DATE