Mountain View Family Medicine
11546 Chapman Highway, Suite B
Seymour, TN 37865
Phone (865) 579-5080
Fax (865) 573-8998

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 #			

If patient is a minor, please fill out this portion

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

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:

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.