Pediatric Gastroenterology and Nutrition Services
1975 Town Center Blvd., Knoxville, TN 37922
Phone: 865/546-3998 Fax: 865/546-1123

Patient Information

Date _____
Last Name _____
First Name _____ Middle _____
Sex _____ Date of Birth _____ SS# _____
Street Address _____
City _____ State _____ Zip Code _____
Primary Phone ( ) _____
Race: ___ Asian ___ Biracial ___ American Indian or Alaska Native ___ Native Hawaiian or Other Pacific Islander
___ Caucasian/White ___ Black or African American
___ Other: _____ ___ Prefer not to answer
Ethnicity: ___ Hispanic ___ Non-Hispanic
Preferred Language for Healthcare Discussion _____

Physician Information

Referring Doctor _____
Reason for Visit _____
Primary Care Doctor _____
Phone ( ) _____

Mother/Guardian Information

Last Name _____
First Name _____ Middle _____
Street Address _____
City _____ State _____ Zip Code _____
Primary Phone ( ) _____
Secondary Phone ( ) _____
Work Phone ( ) _____
SS# _____ DOB _____
Email Address _____
Employer _____
Marital Status (*Check one of the following*)
__Single __Married __Divorced __Widowed __Separated

Emergency Contact

Please list the name of a relative or friend that does not live with you and can be contacted in case of an emergency.
Name _____
Relationship to Patient _____
Phone ( ) _____

Insurance

Primary Insurance Company _____
Who carries the insurance on the patient?
Name _____ DOB _____
Relationship to Patient _____
Effective date: _____
Policy # _____ Group # _____

Secondary Insurance Company _____
Who carries the insurance on the patient?
Name _____ DOB _____
Relationship to Patient _____
Effective date: _____
Policy # _____ Group # _____

Father/Guardian Information

Last Name _____
First Name _____ Middle _____
Street Address _____
City _____ State _____ Zip Code _____
Primary Phone ( ) _____
Secondary Phone ( ) _____
Work Phone ( ) _____
SS# _____ DOB _____
Employer _____
Email Address _____
Marital Status (*Check one of the following*)
__Single __Married __Divorced __Widowed __Separated

Preferred Pharmacy _____ Pharmacy Phone # _____

Preferred email for use with patient portal _____

☐ Refuse this information

PLEASE COMPLETE REVERSE SIDE

Agreement and Consent

I hereby give consent for the following individuals to bring my child to GI For Kids, PLLC, for treatment and to exchange necessary information with GI For Kids, PLLC. This request will remain in effect until revoked by me in writing.

_____ / _____

_____ / _____

Signature of Parent/Legal Guardian _____

Relationship to Patient _____ Date _____

1. I am the parent or legal guardian authorized to act on the patient's behalf. I hereby authorize medical services to be provided to the patient by the MDs, mid level providers, dietitians and medical staff of GI For Kids, PLLC as necessary.

2. Acknowledgment of Receipt of Privacy Notice: I acknowledge receiving upon request, a copy of the provider's notice of privacy policies. I consent to the provider's use of protected health information as described in the notice of treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

3. Referrals: I understand that if the patient's insurance plan requires a referral from the primary care physician, the referral must be obtained prior to the visit in order to ensure the patient's maximum benefit from the insurance plan. I further understand if the referral is not in place, I agree to sign a waiver taking full responsibility for payment due for services rendered by GI For Kids, PLLC.

4. I understand that all services may not be covered by the patient's insurance plan. I understand that I am responsible to pay for all services rendered not covered by the patient's insurance. I understand that any unpaid account balance owed to GI For Kids, PLLC by me, may be turned over to a collection agency that will include collection agency fees and may affect my credit rating.

5. I hereby authorize GI For Kids, PLLC, to release information to referring MDs, insurance companies, government agencies, etc., as necessary, in order for GI For Kids, PLLC to obtain payment for services rendered.

6. I authorize and request payment to be made directly to GI For Kids, PLLC for insurance benefits payable for services provided by GI For Kids, PLLC. This authorization expressly includes benefits that are provided by TennCare and/or any other public or private insurance plan.

7. Reminder/Notification: I grant GI For Kids, PLLC permission to leave a message regarding appointments, discussion of treatment plan, etc. at the phone numbers I listed on the registration form.

8. I grant permission for the patient's photo to be taken and retained in his/her personal medical chart or file for identification purposes only.

9. Arriving 15 minutes late or more for a scheduled appointment may result in your appointment needing to be rescheduled. If you need to reschedule or cancel your appointment , please call our office prior to your appointment. Otherwise, it will be marked as a "no-show". After 3 no-show appointments, you may be dismissed from our practice at our discretion.

Patient's Name _____

Signature of Parent/Legal Guardian _____

Relationship to Patient _____

Date _____