Welcome to our practice!

1346 DOWELL SPRINGS BOULEVARD•KNOXVILLE, TN 37909
PHONE: (865) 588-2753 FAX: (865) 588-7418
SANGEETHA M. KODOTH, MD

Patient's full name: ____
Last *First* *Middle*

Are there any other names under which we might find you/your child's medical records (maiden name, name prior to adoption)?

If so, please list: ____

Home Address ____
Street *City* *State* *Zip*

Home phone: ___________________________**Cell**: _____________________________ **Work phone**: __________________________

Preferred Contact Number: (please choose one) Home Phone ( ) Cell Phone ( ) Work Phone ( )

Email Address: ____ **Student:** Y N Full time Part time

Birth Date: _______________________________________ **Social Security Number**; _______________________________________

Race:
( ) American Indian/Alaskan Native
( ) Asian
( ) African American
( ) Other ___________
( ) White
( ) Prefer not to answer

Ethnicity:
( ) Hispanic/ Latino
( ) Non -Hispanic/ Latino
( ) Prefer not to answer

Preferred Language:
( ) English
( ) Spanish
( ) Other ________________
( ) Prefer not to answer

Patients Employer: ____ **Occupation:** __________________________

Work address; ____
Street *City* *State* *Zip*

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed **Sex**: ( ) Female ( ) Male

Spouse or Parent name: ____

Address (if different): ____
Street *City* *State* *Zip*

Home phone: _______________________ Cell: _______________________________ Work Phone: ___________________________

HOW did you learn about our practice: (Please check all that apply): □ Our Web Site □ Other Web Site(Name)_________________________

□ Expo (Name) _________________ □ TV (Name) ________________ □ Radio (Name) ______________ □Newspaper(Name) _______________

□ Magazine (Name) __________ □ Friend or Family Member (Name) ______________________________ □ Phone Book □ On line Yellow Pages

□ Search Engine (Name)________________________________ □Other _______________________________

Referring Physician's Name: ____Phone: ____________________________________

Referring Physician's Address: ____
Street *City* *State* *Zip*

Primary Care Physician Name: ____Phone:_____________________________________

Primary Physician Address: ____
Street *City* *State* *Zip*

Preferred Pharmacy Name: ____ **Phone:** __________________________

Pharmacy Address: ____
Street *City* *State* *Zip*

Please continue on the other side

PRIVACY INFORMATION: You will receive a copy of our Notice of Privacy for Personal Health Information Policy. Extra copies can be found in our lobby, and can also be printed from our web site. The following statements direct us regarding how we handle your personal information. I authorize Allergy Specialists of Knoxville, PLLC:

1. To notify me by: (mark all that apply) ( ) mail ( ) phone ( ) email of appointment reminders and/or to contact me regarding medical information (including test results). A message may be left on my home answering machine. YES NO

2. If unable to reach me at home, the practice of Allergy Specialists of Knoxville, PLLC, may leave a message where I work, asking me to return their call YES NO

3. Please list the names of family members, if any, with whom we may share your medical information: ______________________________________

____

I acknowledge I have received a copy of Allergy Specialists of Knoxville, PLLC's Notice of Privacy for Personal Health Information.

____ Date: ________________________
Signature of Patient or Person Authorized to Consent for Patient

Please print patient's name: ____ Patient's Date of Birth: ___________________

Please print name of person signing for patient (if applicable):____

Relationship to patient: ____

INSURANCE INFORMATION (Please allow us to make copies of your insurance cards.)

Primary Insurance: ____ Effective Date of Coverage: __________________

Secondary Insurance: ____ Effective Date of Coverage: __________________

INSURED'S INFORMATION (who is the primary holder of the insurance?)

Insured's full name: ____ Relationship to the patient: __________________

Insured's Birth Date: ________________________ Home phone: _______________________ Cell: ____________________

Insured's Employer: ______________________________________Insured work phone: __________________________

Employer Address: ____
Street *City* *State* *Zip*

Insured's Social Security Number: _________________________ Drivers License Number: _________________ State: _______

BILLING INFORMATION IF PATIENT IS A CHILD (under 18 yrs): (person attending the appointment with the child)

Responsible Party Name: ____

Relationship to Patient: ___________________________ Home Phone: ___________________________ Cell: __________________

Home Address: ____
Street *City* *State* *Zip*

Employer: _____________________________________ Work Phone: ____

Employer Address: ____

EMERGENCY INFORMATION: In an emergency, notify: ____

Relationship to patient: ____________ Home phone: ___________________ Cell: ___________________Work: ______________

Please list any doctor you would want to receive a copy of your evaluation. (Referring physicians will automatically receive a copy, unless you tell us otherwise): ____