**Unicoi Medical Associates**
P.O. Box 399
Erwin, TN 37650
**Jason A. Colinger, D.O., FAAFP**
**Victoria L. Osborne, R.N., F.N.P.**
**W. James Aderhold, Jr, PA-C, MS**

**PLEASE PRINT**
**ALL FIELDS REQUIRED TO BE FILLED**

**PATIENT INFORMATION**

Patient Name: _____
Last First MI

Address: _____

_____
City, State Zip Code

Phone# _____

Cell Phone # _____

2nd Phone or Work# _____

Patient Social Security# _____

Physician / Provider : _____

**GUARANTOR (Person responsible for bill)**

Name: _____

Address: _____

_____
City, State Zip Code

Phone# _____

Guarantor SS#: _____

Guarantor's DOB: _____

Patient Sex: _____Male _____ Female

**Date of Birth**: _____

Marital Status: _____ Single
_____ Married

**REQUIRED**
**Please check one**:
____ American Indian or Alaska Native
____ Asian
____ African American
____Native Hawaiian
____ White
____ Other Race

**Please check Ethnic Group:**
____ Hispanic
____ Latino
____ Not Hispanic or Latino

**Please check Primary Language:**
____ English
____ Spanish
____ Other

Email Address: (**FOR PATIENT PORTAL ONLY**)

_____

**ASSIGNMENT AND RELEASE**
I hereby authorize and direct my insurance benefits to be paid to Unicoi Medical Associates. I am financially responsible for all services to me including the balance remaining after payment of possible insurance benefits. I also authorize release of any medical information necessary to process this claim. To the best of my knowledge, the information given is correct. Default of any payment(s) will include collection cost being added to the final balance before being sent to a collection agency.

Patient / Guarantor Signature: _____ Date: _____
(Patient or Guardian of Minor)

**Payment is expected when service is rendered unless other arrangements are made in advance**

## EMERGENCY CONTACT:

Name _____ Address: _____

Phone: _____ 2nd Phone_____

Relationship: _____

## PREFERRED PHARMACY:

Name: _____ Phone_____

**Privacy Information (Required)**

May we call the telephone number listed and leave a message on an answering machine or with a family member with any appointments or results of tests performed? Yes ☐ No ☐

Do you currently have an Advanced Directive or Living Will? Yes ☐ No ☐

Do you currently have a Power of Attorney? Yes ☐ No ☐

Do you wish to share information regarding your health with a family member or friend? Yes ☐ No ☐

Please name the person(s): _____