PARKWEST WOMEN'S SPECIALISTS

9314 Parkwest Blvd. | Ste. 100 | Knoxville, TN 37923
O: (865) 690-7677 | F: (865) 690-7327

Patient Information

Patient's Name _____ DOB _____ SS# _____

Home Address _____ Apt # _____

City _____ State _____ Zip Code _____

PO Box #_____ City _____ State _____ Zip Code _____

Home # _____ Cell # _____ Work # _____

We use AthenaNet for our Patient Portal. To utilize this function, we need an e-mail address on file. Would you like to sign up to use the Patient Portal for additional communications, receiving test results, updating patient information and Billing? YES____ DECLINED____

E-mail _____ Occupation / Employer _____

Marital Status (please circle one): Single Married Divorced Separated Widow

Race (please check one): American Indian/Alaska Native ____ Asian/Pacific Islander ____ Black/African American____
Hispanic or Latino____ White/Caucasian____ Multiracial____ REFUSED/DECLINED____

Primary Language: _____

Emergency Contact _____ Relationship _____ Phone #_____

Pharmacy Name/Address _____ Phone # _____

Primary Care Physician _____ Phone #_____

Preferred Delivery of Appointment Reminders (please check *all* that apply): E-mail____ Text____ Voice____ DECLINED REMINDERS___

How did you hear about us (please check *all* that apply): Patient in Practice____ PCP Referral____ Insurance____ Social Media____
Radio____ Google____ Hospital ____ OTHER _____

INSURANCE INFORMATION

Primary Insurance Carrier_____ Policy Holder's Name_____

Member ID #_____ Group #_____ Policy Holder's DOB_____

Policy Holder's Phone #_____ Policy Holder's Sex_____

Relationship to Patient: Self____ Spouse____ Father____ Mother____

Secondary Insurance Carrier_____ Policy Holder's Name_____

Member ID #_____ Group #_____ Policy Holder's DOB_____

Policy Holder's Phone #_____ Policy Holder's Sex_____

Relationship to Patient: Self____ Spouse____ Father____ Mother____

My insurance requires a referral when seeing a specialist (please circle one): YES NO
My insurance requires my lab or pathology work to be sent to a specific lab (please circle one): YES NO
If YES, please specify lab: _____

I understand that if my insurance requires a referral for my visit, it be recieved by Parkwest Women's Specialists in order to recieve maximum benefits from the insurance company. If a referral was not previously arranged, I have been given the opportunity to obtain a referral or reschedule my appointment. I understand I must provide a seperate authorization before other disclosures be made.

Patient Name (print and signature) : _____ Date : _____