KOC
Knoxville Orthopaedic Clinic

Patient Registration

MRN # _____
Physician _____

About The Patient

Full Name _____ (Last,) _____ (First) ____ (MI) _____ (Maiden Name) SSN _____

Birthdate _____ Sex _____

Street Address _____
Apt/Lot # City State Zip

Mailing Address _____
Apt/Lot # City State Zip

Race _____ Language _____ Ethnicity _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed
VOLUNTARY

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Employer _____ Address _____

Occupation _____

Emergency Contact Name _____ Phone # _____

Your Spouse or Parent

Name: _____ Birthdate: _____

Address _____ Phone #: _____

Employer: _____ Emp. Phone #: _____

SSN (if financially responsible) _____

Insurance

Primary

Insurance Co. Name _____

Policy #: _____ Group #: _____

Cardholder Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

Secondary

Insurance Co. Name _____

Policy #: _____ Group #: _____

Cardholder Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

Reason For Visit

What body part are we seeing you for? _____ ☐ Right ☐ Left

This is (check one) ☐ Injury ☐ Onset of Pain

Date on injury or onset of pain _____

Type of accident: Auto ☐ Worker's Comp ☐ Other ☐

Referring Physician _____ Primary Physician (if different) _____