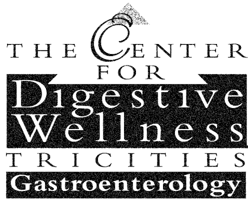

10461 Wallace Alley Lane
Kingsport TN 37663
ph 423.279.1400
fx 423.279.1410
www.digestivewellness.net

Name: ______________________________ **Male / Female**
(Last) (First) (Middle Name)

Date of Birth: ____________ **Social Security Number**: ____________

Mailing Address: ______________________________
(Street Name or PO Box) (City) (State) (Zip Code)

Home Phone: ____________ **Cell Phone**: ____________

Work Phone: ____________ **Alt. Phone**: ____________

Do you have internet access? Yes / No **Email Address**: ____________

Employer: ______________________________

Employer Address: ______________________________

Emergency Contact (Not at your address):

Name: ____________ **Phone**: ____________

Family Physician: ____________ **Referring Physician**: ____________

Marital Status: Single / Married / Widowed / Separated / Divorced

Language: English____ Spanish____ French____ Other____ Refused to Report ____

Race: American Indian or Alaska Native____ Asian____ Black or African American____ White_____
More than one race____ Native Hawaiian____ Other Pacific Islander____ Refused to Report/Unreported_____

Ethnicity: Hispanic or Latino____ Non Hispanic or Latino____ Refused to Report/Unreported____

Spouse/Gaurantor Name: ______________________________ **Male / Female**

Social Security #: ____________ **Date of Birth**: ____________

Employer: ______________________________ **Phone**: ____________

Employer Address: ______________________________

Insurance Company: ______________________________

Subscriber Number: ____________ **Group Number**: ____________

Claims Address: ______________________________

Insurance Subscriber: Self _____ Spouse _____ Parent/Guardian: _____ Other ____________

Secondary Insurance: ______________________________

Subscriber Number: ____________ **Group Number**: ____________

Claims Address: ______________________________

Insurance Subscriber: Self _____ Spouse _____ Parent/Guardian: _____ Other ____________

Pharmacy Name:______________________________ **Phone**: ____________

COPAYS ARE DUE AT TIME OF SERVICE. IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL FROM YOUR PRIMARY DOCTOR, PLEASE OBTAIN BEFORE YOUR VISIT.