COOKEVILLE REGIONAL MEDICAL GROUP
It's the Way WeCARE

Cookeville Regional Medical Group
www.crmchealth.org/CRMG

Reason for your visit: _____

MR # _____

PATIENT INFORMATION

_____
Last Name

_____
First Name Middle Initial

SSN:_____--_____--_____ DOB:_____

Age:_____ Gender: ❑ M ❑ F

Address: _____

City:_____

State:_____Zip Code:_____

Home Phone: ( )_____

Cell Phone: ( )_____

Marital Status: ❑ S ❑ M ❑ D ❑ W

Race/Ethnicity: _____

Preferred Language:_____

Employer: _____

Occupation: _____

Work Phone: ( ) _____

Spouse Name (Parent, if child): _____

Spouse/Parent SSN:_____--_____--_____

Spouse/Parent DOB:_____

Spouse/Parent Employer:_____

Spouse/Parent Employer Phone: ( ) _____

Referring Physician: _____

DO YOU HAVE A:

❑ Living Will

❑ Power of Attorney for Healthcare

❑ Power of Attorney for Financial Affairs

PATIENT PORTAL

_____
Please list your email address to enroll in our patient portal.

❑ I do not want to sign up for the patient portal.

EMERGENCY CONTACT INFORMATION

_____
Last Name

_____
First Name

Phone: ( ) _____

_____
Relationship

INSURANCE INFORMATION
PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST

RESPONSIBLE PARTY INFORMATION
❑ SAME AS PATIENT

_____
Last Name

_____
First Name Middle Initial

SSN:_____--_____--_____DOB: _____

Address: _____

City:_____

State:_____ Zip Code: _____

Home Phone: ( )_____

Cell Phone: ( )_____

Employer: _____

Work Phone: ( ) _____

Please list any person that health information may be released to:

NAME	RELATIONSHIP	PHONE

_____
HOW DID YOU HEAR ABOUT US