APPOINTMENT:
Date: _____
Time: _____
Chart #: _____
Acct #: _____

Neurosurgical Associates, P.C.
865-524-1869

PHYSICIAN'S NAME:
- ❑ Dr. Lewis W. Harris
- ❑ Dr. William E. Snyder, Jr.
- ❑ Dr. Richard P. Boyer
- ❑ Dr. Todd B. Abel
- ❑ Dr. Joshua A. Miller
- ❑ Dr. Michael T. Walsh
- ❑ Dr. Jennifer Gentry Savage
- ❑ Dr. James A. Killeffer
- ❑ Dr. Kent L. Sauter
- ❑ Dr. Christopher P. Gallati

OFFICE :
- ❑ UT - Medical Bldg. C, Ste 360
- ❑ CHILDREN'S - MOB Ste 110
- ❑ TURKEY CREEK - 11440 Parkside Drive, Ste 302
- ❑ MARYVILLE - 603 Smithview Drive
- ❑ MORRISTOWN - 420 W Morris Blvd, Ste 400D
- ❑ SEVIERVILLE - 1130 Middle Creek Rd., Ste 120
- ❑ JEFFERSON CITY - 110 Hospital Drive, Ste G50

PATIENT INFORMATION:

NAME			SSN
ADDRESS			SEX: Male Female
CITY	STATE	ZIP	DATE OF BIRTH
HOME PHONE:	MARRIED SINGLE OTHER: _____		AGE
NAME OF FAMILY PHYSICIAN	PHONE	ADDRESS	
NAME OF PHYSICIAN WHO REFERRED YOU HERE			

RESPONSIBLE PARTY:

NAME			SSN
ADDRESS			SEX: Male Female
CITY	STATE	ZIP	DATE OF BIRTH
HOME PHONE:	RELATIONSHIP TO PT.		
EMPLOYER'S NAME		WORK PHONE	
EMPLOYER'S ADDRESS			

INSURANCE INFORMATION:

INSURANCE COMPANY NAME & ADDRESS	ID NUMBER	GROUP #	POLICY HOLDER'S NAME
1			
2			
3			

PLEASE PROVIDE THE NAME, ADDRESS, DATE OF BIRTH AND EMPLOYER OF THE POLICY HOLDER IF NOT THE PATIENT

ACCIDENT INFORMATION:

Is your illness the result of an accident? ____ yes ____ no
If yes, what type of accident?
_____ Automobile
_____ Other

PRIVACY NOTICE:

I have been given the opportunity to review the Neurosurgical Associates, P.C., Notice of Privacy Practices.

_____
Signature of Patient or Legal Guardian

REVISED 07-28-15