Hamilton Health & Wellness
201 W. Liberty Ave. 101 Covington TN 38019-2500

Patient Forms

Basic Information

Full Name _____

First   Middle   Last   Suffix

Sex ◯ Male ◯ Female ◯ Unknown   **Date of Birth** _____ / _____ / _____

Primary Phone ◯ Home   ◯ Mobile   ◯ Work   **Phone Number** _____

Email _____   **Social Security Number** _____

Address Line 1 _____   **Address Line 2** _____

City _____   **State** _____ **Zip** _____

Marital Status _____   **Maiden Last** _____

Driver's License State _____   **Driver's License #** _____

Demographics

Sexual Orientation _____   **Gender Identity** _____

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify   **Ethnicity** _____

Race _____   **Language** _____

Emergency Contact

Relationship to Contact _____

Full Name _____

First   Middle   Last

Primary Phone ◯ Home   ◯ Mobile   ◯ Work   **Phone Number** _____

Email _____

Address Line 1 _____   **Address Line 2** _____

City _____   **State** _____ **Zip** _____

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name _____
First   Middle   Last

Primary Phone ◯ **Home**   ◯ **Mobile**   ◯ **Work**   **Phone Number** _____

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company _____   **Policy Number** _____

Insurance Plan _____   **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____   **Address Line 2** _____

City _____   **State** _____   **Zip** _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name _____
First   Middle   Last

Sex ◯ Male   ◯ Female   ◯ Unknown   **Date of Birth** _____ / _____ / _____

Policy ID Number _____   **Social Security Number** _____

Policy Holder Address _____   **Address Line 2** _____

City _____   **State** _____   **Zip** _____

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company _____   **Policy Number** _____

Insurance Plan _____   **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____   **Address Line 2** _____

City _____   **State** _____ **Zip** _____

Relationship to Secondary Policy Holder _____

If you are not the secondary policy holder, please fill out the following:

Full Name _____
First   Middle   Last

Sex ◯ Male   ◯ Female   ◯ Unknown   **Date of Birth** _____ / _____ / _____

Insurance ID Number _____   **Social Security Number** _____

Policy Holder Address _____   **Address Line 2** _____

City _____   **State** _____ **Zip** _____

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us? _____