CHATTANOOGA AUTISM CENTER

CHATTANOOGAAUTISMCENTER.ORG
(423) 531-6961
1400 MCCALLIE AVENUE, SUITE 100
CHATTANOOGA, TN, 37404

PATIENT INFORMATION

_____ _____ _____ M F _____
First Name MI Last Name Circle Date of Birth

_____
Street Address City State Zip

_____ _____ □ Ok to send appt. reminders
Social Security Number Email Address

(_____)_____ □ Ok to leave message (_____)_____ □ Ok to leave message
Home Phone Work Phone

(_____)_____□ Ok to leave message and/or text appointment reminders
Cell Phone

_____ (_____)_____ (_____)_____
Primary Care Physician (PCP) PCP Phone PCP Fax

_____ (_____)_____ (_____)_____
Person Responsible for Account Home Phone Work Phone

PRIMARY INSURANCE INFORMATION

_____ Patient's relationship to insured □ Self □ Child □ Spouse
Name of Primary Insurance Company

_____ _____ _____ _____
Primary Cardholder's First Name Last Name Date of Birth Social Security #

_____ _____ _____
Insured's Policy Number/ID Number Insured's Group Number Insured's Employer

SECONDARY INSURANCE INFORMATION

_____ Patient's relationship to insured □ Self □ Child □ Spouse
Name of Secondary Insurance Company

_____ _____ _____ _____
Primary Cardholder's First Name Last Name Date of Birth Social Security #

_____ _____ _____
Insured's Policy Number/ID Number Insured's Group Number Insured's Employer