TLC PEDIATRIC MEDICAL GROUP PATIENT REGISTRATION FORM

Account #_____
Last Name_____
First Name _____ Middle Initial _____
Address_____
City, State, Zip _____
Gender [ ]M [ ]F
Sibblings Names

DOB_____
Social Security #_____
Home Phone _____
Cell Phone # _____
Referring Doctor _____
Address_____
Telephone_____

	Gender	
_____	[ ]M [ ]F	Sibbling DOB: _____
_____	[ ]M [ ]F	Sibbling DOB: _____
_____	[ ]M [ ]F	Sibbling DOB: _____

RESPONSIBLE PARTY

Mother's Information _____
Phone: Home # _____ Cell # _____
Name _____
Address _____
City, State, Zip _____
Date of Birth _____
Social Security _____
Driver's License # _____
Employer_____
Address _____
Telephone #_____

Father's Information _____
Phone: Home # _____ Cell # _____
Name _____
Address _____
City, State, Zip _____
Date of Birth _____
Social Security _____
Driver's License # _____
Employer _____
Address _____
Telephone # _____

INSURANCE INFORMATION

Primary Insurance _____ Co pay _____
Address _____
City, State, Zip _____
Telephone # _____
Effective Date _____
Secondary Insurance _____ Co pay _____
Address _____
City, State, Zip_____
Telephone # _____
Effective Date _____

Policy Owner/Subscriber _____
Insured Policy ID_____
Group #_____
Patient relation to Owner of policy _____
HMO [ ] PPO [ ] Other _____
Policy Owner/Subscriber _____
Insured Policy ID_____
Group #_____
Patient relation to Owner of policy_____
HMO [ ] PPO [ ] Other_____

EMERGENCY CONTACT INFORMATION

Name _____
Relation to Patient_____

Home Phone _____
Work Phone _____
Mobile Phone or Pager_____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I authorize TLC Pediatrics Medical Group's physicians to provide care for my child_____
and hereby authorize TLC Pediatrics Medical Group to release any medical information necessary to process insurance claims.

Signature_____ Date_____

Any co pay or deductible is payable at the time of service by person who brings the patient to our office, regardless of relationship status.