

PATIENT REGISTRATION FORM

Patient Information

Patient Last Name:	First Name:	MI:	Today's Date:
Date of Birth:	Patient SSN#:	Home Phone #:	
Home Street Address:	City:	State:	Zip Code:
Primary Doctor (PCP):	Preferred Pharmacy:	Pharmacy Phone:	

Policy Holder

Last Name:	First Name:	MI:	Relationship to Patient:
Date of Birth:	SSN#:	Home Phone #:	
Work Phone: Ext:	Fax:	email:	
Home Street Address:	City:	State:	Zip Code:

Insurance Plan

Primary Insurance Company:	Group #:	Policy #:
Copayment:	Effective Date:	Expiration Date:
Employer:	Employer Address:	Secondary Insurance Plan: ID#:

Authorization

I authorize the release of any medical information necessary to process insurance claims and the release of information back to my physician. I also authorize payment of medical benefits to TLC Pediatrics for services rendered. In the event that my medical insurance does not pay for the services rendered, I agree to pay TPC Pediatrics the usual and customary fees for these services.

Signed: _____

Date: _____

PS -- How Did You Hear About Us?: