Pediatrics
"TLC for your kids."

Today's Date:_____/_____/_____

# PATIENT REGISTRATION

Child's Name _____ Date of Birth: _____

Legal Sex: Male Female Other Gender (if different from legal sex): _____

**PARENT** #1 _____ DOB _____ SS#* _____

This is: Mother Father Step-Mother Step-Father Foster Parent Other: _____

Address _____ Cell Phone _____

City/State/Zip _____ Alternate Phone _____

Employer/Occupation _____

**PARENT** #2 _____ DOB _____ SS#* _____

This is: Mother Father Step-Mother Step-Father Foster Parent Other: _____

Address _____ Cell Phone _____

City/State/Zip _____ Alternate Phone _____

Employer/Occupation _____

Parents are: Married - Divorced - Custodial parent if divorced _____ Separated - Living Together Other: _____

*we only need your SS# if your insurance requires

**Insurance Information (You must provide us with a copy of your current insurance card at every visit)**

Do you have a **primary** insurance? Yes, No

Insurance Name _____ ID# _____ Group# _____

Policy Holder _____ Insurance is obtained through: Employer or Self-Funded

Policy Holder Address _____ City/State/Zip _____
***(if different from home address)***

Do you have a **secondary** insurance? Yes, No & _____ **Initial if you do not have any other healthcare coverage**

Insurance Name _____ ID# _____ Group# _____

Policy Holder _____ Insurance is obtained through: Employer or Self-Funded

Policy Holder Address _____ City/State/Zip _____
***(if different from home address)***

**Authorization of Treatment and Assignment of Benefits:**

I authorize TLC Pediatrics, to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to TLC Pediatrics, for any and all medical or procedural benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse TLC Pediatrics for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits.** I also understand that I am responsible for advising TLC Pediatrics of any and all changes to my insurance. **Payment of co-pays are due on date of service.** Failure to pay co-pay at that time may result in an additional billing charge as outline in Financial Policy. **PLEASE SEE FINANCIAL POLICY**.

Signature _____ Relationship _____ Date _____

*A photocopy or scan of this authorization shall be considered as effective and valid as the original.*