Tots N Teens Pediatrics

Every child is special here!

Patient Profile

PATIENT INFORMATION

Social Security # _____

Patient _____ _____ _____ Ethnicity _____
First Name Last Name Middle Initial Sex -- M F

Address _____ **Date of Birth** _____

_____ **Home Phone** _____

Father _____ _____ _____ _____

_____
First Name Last Name M.Initial DOB SS#

Address _____ **Home Phone** _____

_____ **Cell Phone** _____

Employer _____ **Occupation** _____**Work Phone** _____

Mother _____ _____ _____ _____ _____
First Name Last Name Initial DOB SS#

Address _____ **Home Phone** _____

_____ **Cell Phone** _____

Employer _____ **Occupation** _____**Work Phone** _____

PATIENT INSURANCE INFORMATION

Primary Insurance Company _____**Phone #** _____

ID# _____ **Group#** _____ **Group Name**_____

Insurance Address _____

_____ **Effective Date** _____

Subscriber Name _____ _____ _____
First Name Last Name Middle Initial

Date of Birth _____ **Relationship to Patient** _____

Address _____ **Phone #** (H)_____

_____ **Cell #/Work #** _____

Secondary Insurance Company _____**Phone #** _____

ID# _____ **Group#** _____ **Group Name**_____

Insurance Address _____

_____ **Effective Date** _____

Subscriber Name _____ _____ _____
Last Name First Name Middle Initial

Tots N Teens Pediatrics

Every child is special here!

Date of Birth _____ **Relationship to Patient** _____

Address _____ **Phone #** _____

_____ **Cell #/Work #** _____

Patient_____

DOB_____

EMERGENCY CONTACT (OTHER THAN PARENT)

_____ _____ _____

_____

First Name Last Name Middle Initial SS#

Address _____ **Home Phone** _____

_____ **Cell Phone** _____

Relationship to Patient _____

SIBLINGS INFORMATION

_____ _____ _____ _____

Last Name First Name Middle Initial Date of Birth

_____ _____ _____ _____

Last Name First Name Middle Initial Date of Birth

_____ _____ _____ _____

Last Name First Name Middle Initial Date of Birth

In the absence of the parent/legal guardian, I give the following person(s) permission to seek treatment for my child/children.
I also realize that the person with my child may have access to pertinent protected health information if medically necessary.
This authorization will be valid for one year from the date listed below.

_____ _____ _____

Person Name Phone # Relationship

_____ _____ _____

Person Name Phone # Relationship

_____ _____

Signature of Parent/Guardian Date

I, the patient/parent/guardian give Tots N Teens Pediatrics permission to release information to my daycare/school upon request.
Ex: Immunization record, dispensing of medication, and or absentee note due to appointment.

_____ _____

Signature of Patient/Parent/Guardian Date

I understand that payment in full is expected at the time of service. However, in the event that Tots N Teens Pediatrics PLLC files claims on my behalf I authorize all benefits to be paid directly to Tots N Teens Pediatrics. Any charges not covered by insurance will be my responsibility. I authorize Tots N Teens Pediatrics PLLC and/or the rendering physician(s) to release all information
required by my insurance company to file for medical benefits.

_____ _____

Signature of Parent/Guardian Date