TUCSON CENTRAL PEDIATRICS

Patient Registration

Please Print

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

*D.O.B.:*_____/_____/_____ *Sex:*_____ *Primary Language:* _____

Patient's Social Security # _____-_____-_____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White

Child 2: *Last Name:* _____ *First Name:* _____ *MI:* _____

*D.O.B.:*_____/_____/_____ *Sex:*_____ *Primary Language:* _____

Patient's Social Security # _____-_____-_____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White

Child 3: *Last Name:* _____ *First Name:* _____ *MI:* _____

*D.O.B.:*_____/_____/_____ *Sex:*_____ *Primary Language:* _____

Patient's Social Security # _____-_____-_____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race:* Asian / Black / Hawaiian / White

Mailing Address:

_____

(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (_____) _____-_____

Who lives at this household? _____

Insurance:

Primary Policy:

Policy Holder's Name _____ *Policy Holder's SSN*_____

Policy Holder's Birth Date _____ *Policy Holder's Sex: Male / Female* *Relation to Pt.* _____

Insurance Carrier _____ *Effective Date* _____

*Address*_____ *ID#* _____ *Group #*_____

Secondary Policy:

Policy Holder's Name _____ *Policy Holder's SSN*_____

Policy Holder's Birth Date _____ *Policy Holder's Sex: Male / Female* *Relation to Pt.* _____

Insurance Carrier _____ *Effective Date* _____

*Address*_____ *ID#* _____ *Group #*_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Tucson Central Pediatrics, P.C. to release medical information requested by insurance companies or any public agency which may be assisting in payment of the above patient's medical care.

AUTHORIZATION OF INSURANCE BENEFITS: I authorize payment of benefits to be paid to Tucson Central Pediatrics, P.C. - I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits when coverage is subject to coordination of benefits in the event of default, I agree to pay all costs of collection, including attorney fees.

This release of medical information and assignment of benefits is considered in force from the date of signing until revoked in writing.

Signature_____ Date_____

(Responsible Party's Signature)

Patient Registration

Contact 1: *Name:* _____ *Relation to Patient* _____

Lives with patient? Yes / No *Date of Birth:*_____/_____/_____ *Social Security #*_____-_____- _____

Work Phone: (_____) _____-_____ *Cell Phone: (_____)* _____-_____

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home Email / Work Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notification: Cell Phone / Home Email / Work Email

Contact 2: *Name:* _____ *Relation to Patient* _____

Lives with patient? Yes / No *Date of Birth:*_____/_____/_____ *Social Security #*_____-_____- _____

Work Phone: (_____) _____-_____ *Cell Phone: (_____)* _____-_____

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications, list their preferences here: _____

_____

_____

School Name: _____ Address: _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____

Emergency Contacts, <u>other than parents</u>: Name & Relationship

1: _____ *Phone: (_____)* _____-_____

2: _____ *Phone: (_____)* _____-_____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____