TRI-COUNTY PEDIATRIC ASSOCIATES, P.C.
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PATIENT INFORMATION

(Please print clearly and answer all questions)

Child's Name:_____ **Date of Birth**:_____ **Sex**: M or F
Address:_____City:_____Zip:_____
Home Phone: _____ Place of Birth: _____ Race:_____
Previous Pediatrician (if applicable): _____ Dentist: _____

Child lives with: Both Parents:____ (same address) Mother Only: ___ Father Only: ___ Both Parents :____ (separate address) Other: _____ (please explain)

Information for First Parent:
Name: _____ Date of Birth _____ Cell Phone _____
Address: _____ City: _____ Zip: _____
Place of Work: _____ Occupation: _____ Work Phone: _____
Work Address: _____ City: _____ Zip: _____

Information for Second Parent:
Name: _____ Date of Birth: _____ Cell Phone: _____
Address: _____ City: _____ Zip: _____
Place of Work: _____ Occupation: _____ Work Phone: _____
Work Address: _____ City: _____ Zip: _____

Insurance Coverage:
Primary Insurance: _____ Policy #_____
Subscriber Name: _____ Group # _____
Secondary Insurance: _____ Policy # _____
Subscriber Name: _____ Group # _____

Party Responsible for Bill: _____ Relationship to Child: _____
Emergency Contact (other than parent) _____ Phone: _____
Names of Other Children in Family: _____
Persons Authorized to Seek **Urgent Medical Care** for Child: (other than parent)
Name: _____ Relationship: _____
Name: _____ Relationship:_____

PARENT/GUARDIAN MUST BE PRESENT AT ALL WELL CHILD VISITS—IMMUNIZATIONS WILL NOT BE ADMINISTERED IF PARENT/GUARDIAN IS NOT PRESENT AT VISIT

AUTHORIZATION

I authorize Tri-County Pediatric Associates to release medical information to my insurance carrier and other physicians requesting information on my child's behalf. I also authorize payment be made directly to Tri-County Pediatric Associates for services rendered to my child. I also attest that I am the parent/legal guardian and I am responsible for any charges incurred at the time of my child's visits. I have reviewed all the information on this form and it is correct. If I am responsible for a co-payment and do not make a payment at the time of service, I understand that there will be a $10 billing charge added to my account.

I understand that my insurance company provides coverage for medically necessary services for their members; however, it is my responsibility to insure that my coverage is in force at the time of visit and that the correct Primary Care Physician is listed with my insurance company. I acknowledge responsibility for payment of any services provided which are not covered by my insurance policy.

_____ _____
Signature of Parent/Legal Guardian Date