

PEDIATRIC REGISTRATION FORM

Date: _____

Patient Number: _____

PATIENT INFORMATION

First Name	Middle	Last Name	Nickname
Date of Birth	Sex	Social Security Number ()	
Patient Address (Street, Route, Apt. No., Etc.)			Home Phone Number ()
City	State	Zip Code	Cell Phone/Beeper/Pager No. ()
Referring Physician	Primary Care Physician/Pediatrician Name		PCP Office Number

INSURANCE INFORMATION

Primary Insurance Company Name	Policy Number	Group/Plan Number
Insured's Name	Insured's Date of Birth	Relationship to Patient
Secondary Insurance Company Name	Policy Number	Group/Plan Number
Insured's Name	Insured's Date of Birth	Relationship to Patient

PARENT/GUARDIAN INFORMATION

Mother's Information	Father's Information
Name	Name
Mother's SS # DOB	Father's SS # DOB
Spouse's Name	Spouse's Name
Address City, ST, Zip	Address City, ST, Zip
Home Phone Number () Cell/Pager Number ()	Home Phone Number () Cell/Pager Number ()
Employer Name Work Phone Number ()	Employer Name Work Phone Number ()



TLC Pediatrics L.L.C.

CONSENT FOR TREATMENT OF A MINOR

I, The parent or guardian of said patient, who i.e. a minor, authorize TLC Pediatrics and all persons acting as agents thereof and all physicians to whom said minor is referred for medical treatment, to furnish all forms of diagnostic, preventative and medical treatment to said minor. This consent shall remain in effect until a written revocation hereof is delivered to TLC Pediatrics LLC.

AUTHORIZATION AND RELEASE

I authorize TLC pediatrics LLC to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to TLC Pediatrics LLC insurance benefits otherwise payable to me.

PAYMENT POLICY

I understand that if TLC Pediatrics LLC is not contracted with my insurance carrier, I must pay in full at the time of service. I understand that my insurance carrier may pay less than the actual bill for services. I also understand that some services provided by TLC Pediatrics LLC may not be covered by my benefit plan. I agree to be responsible for payment of all services rendered. I understand that all Co-payments, Co-insurance and Deductibles are due at the time of service. I understand that any balance generated is due within 10 days of the billing day. I realize that failure to keep this account current may result in TLC Pediatrics LLC being unable to provide additional services.

In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding balances.

NEW BABY

I fully understand that my newborn baby needs to be added to my insurance policy by the two week appointment. If my newborn baby has not been added to the policy I am aware that I am responsible for the office fee.

I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS FORM, NAMELY THE SECTIONS TITLED: CONSENT TO TREATMENT OF A MINOR, AUTHORIZATION AND RELEASE AND PAYMENT POLICY. I AM THE PARENT OF SAID MINOR CHILD, OR THE COURT-APPOINTED GUARDIAN FOR THE PATIENT AND I AM AUTHORIZED TO ACT ON THE PATIENT'S BEHALF TO SIGN THIS RELEASE OF INFORMATION.

SIGNATURE OF PARENT OR GUARDIAN OF PATIENT

DATE

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Bowie MD 20716
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