Tots to Teens Pediatrics
building healthy futures

PATIENT REGISTRATION

Patient Name:_____

Sex:_____Age:_____ Date of Birth:_____ Social Security #:_____

Race:_____Preferred Language:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Telephone #:_____ Cell #:_____ Email:_____

How do you prefer to be contacted to confirm appointments? Phone:_____ Email:_____ Text:_____

Do you vaccinate your children? Yes:_____ No:_____

What is your preferred Pharmacy?_____

Address:_____ Phone #:_____

INSURANCE INFORMATION

(Primary Insurance)
Name of Insurance:_____ Insured ID #:_____

Group #:_____ Insured: **Mother** or **Father (please circle)**

Father's Name: Last_____ First_____ Initial____ DOB:_____

Social Security #:_____

Mother's Name: Last_____ First_____ Initial____ DOB:_____

Social Security #:_____ Mother's Maiden Name: _____

(Secondary Insurance)
Name of Insurance:_____ Insured ID #:_____

Group #:_____ Insured: **Mother** or **Father (please circle)**

Give information for the Parent/Legal Guardian accompanying child if different from above:

Same as above

Name:_____ Relationship to Patient:_____

Social Security #:_____ DOB:_____

I warrant that I am the responsible party for making medical decisions for the child represented in this medical record. I acknowledge that payment is due at the time of service, unless other arrangements have been made. I assume financial responsibility for any and all healthcare services provided to this patient.

Signature of Parent/Guardian:_____ Date:_____