



Patient Information

Please complete all information in each section in order to ensure accurate medical records for your child. Thank you.

■ Welcome

How were you referred to Tennessee Pediatrics? _____

■ Patient Information

Patient Name _____ Sex: F M

Patient Date of Birth _____ Patient Social Security Number _____

Home Telephone Number _____ E-Mail Address _____

Patient Address _____

City _____ State _____ Zip _____

Patient's Primary Pediatrician _____

Other Children in the Family and Date of Birth _____

Mother's Name _____ Father's Name _____

Mother's SSN _____ Father's SSN _____

Mother's Date of Birth _____ Father's Date of Birth _____

Mother's Employer _____ Father's Employer _____

Employer's Phone _____ Employer's Phone _____

■ Primary and Secondary Insurance

Primary Insurance Company _____

Policy Holder's Name _____ Effective Date _____

Secondary Insurance Company _____

Policy Holder's Name _____ Effective Date _____

■ Nearest Relative To Notify In Case of Emergency

Name _____ Phone _____

■ Individuals (other than parents) Who May Authorize Medical Care for Child

Name _____ Phone _____

Name _____ Phone _____

■ Please Read

Our physicians participate with most major insurance plans. Due to constant coverage changes, we cannot guarantee that your insurance company will cover the services we provide. We will file your charges as a courtesy. Should the services not be covered, you will be responsible for the bill. It is your responsibility to pay your co-pay at the time of each visit. We cannot bill you for your co-pay. It is also, your responsibility to make certain that the physician that your child is scheduled to see is on your insurance plan.

I hereby authorize the release of information necessary to process insurance and also authorize my insurance company to pay directly to the physician any benefits due for services rendered.

Signature _____ Date _____

Tennessee Pediatrics Employee: (Information input by) _____ Date _____