Tri-County Pediatrics – Patient Registration Form

Office: ❒ Elkins Park ❒ Chalfont ❒ Northeast ❒ Iďyĺŵy∃Řƨy±fè ❒ Southampton ❒ Warminster

Patient/Parent

Patient Name ______________________________ DOB ____________________

Address ______________________________ Male Female __

City ____________________ State __________ Zip Code ____________________

Home # ________________ Cell # ________________ Work # ________________

Email ____

Race ____________ Ethnicity: Hispanic or Non-Hispanic Preferred Language ____________

Mother/Guardian Name ______________________________ Cell # ________________

Address (if different than patient) ______________________________ 5h. ____________

City ____________________ State __________ Zip Code ____________________

Father/Guardian Name ______________________________ Cell # ________________

Address (if different than patient) ______________________________ 5h. ____________

City ____________________ State __________ Zip Code ____________________

ICE Contact

In Case of Emergency Contact (other than parent) ________________ Tel # ____________

Address ____________________ City/State ____________ Zip Code ____________

Relationship to Patient ______________________________

Health Insurance

Insurance Company Name ______________________________

ID # ______________________________ Group # ____________________

Co-Pay Amount ____________________

Insurance Claims Address ______________________________

City ____________________ State __________ Zip Code ____________ Tel # ____________

Subscriber's Name ______________________________ DOB ________________

Secondary Insurance Name ______________________________ Tel # ________________

ID # ______________________________ Group # ____________________

Pharmacy

Pharmacy Name: ______________________________

Pharmacy #: ______________________________

Insurance Payment Authorization and Release: I hereby authorize my insurance benefits to be paid directly to Tri-County Pediatrics, Inc. and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information requested by my insurance company.

Signature ______________________________ Date ________________