



TPG Pediatric and Adolescent Medicine Patient Registration Form

Patient Information (Please Print ONLY)

Last Name: _____ First Name: _____ M.I.: _____ Birth Date: _____

Age: _____ Sex: Male Female Social Security No.: _____

Street Address: _____ City: _____ State: _____

ZIP: _____ Home Phone No.: (_____) - _____

Other family members treated here: _____

Parent Email: _____

Parent(s) / Legal Guardian Information

Mother's Last Name: _____ First Name: _____ M.I.: _____

Birth Date: _____ Age: _____ Social Security No.: ____ / ____ / ____

Street Address (Or same as patient): _____

Home Phone No.: (_____) - _____ Work Phone No.: (_____) - _____

Occupation: _____ Employer: _____

Name of Spouse (if not Father/Legal Guardian): _____

Father's Last Name: _____ First Name: _____ M.I.: _____

Birth Date: _____ Age: _____ Social Security No.: ____ / ____ / ____

Street Address (Or same as patient): _____

Home Phone No.: (_____) - _____ Work Phone No.: (_____) - _____

Occupation: _____ Employer: _____

Name of Spouse (if not Mother/Legal Guardian): _____

In Case of Emergency

Name of friend/relative (not living at same address): _____

Relationship to patient: _____ Work Phone No.: (_____) - _____

Cell Phone No.: (_____) - _____



Insurance Information

Primary Insurance: Yes No Policy Holder: _____

Relationship to patient: _____ Insurance Company: _____

Insurance Address: _____ Insurance Phone No.: (____) _____ - _____

Member/Subscriber ID: _____ Group/Plan Number: _____

Deductible: \$ _____ Co-Payment: \$ _____

Secondary Insurance: Yes No Policy Holder: _____

Relationship to patient: _____ Insurance Company: _____

Insurance Address: _____ Insurance Phone No.: (____) _____ - _____

Member/Subscriber ID: _____ Group/Plan Number: _____

Deductible: \$ _____ Co-Payment: \$ _____

16+ Year Olds

Optional: I hereby authorize my child (ages 16 years and up only) to receive medical treatment without an authorized person accompanying him/her. _____

Consent

The above information is true to the best of my knowledge. I give consent for treatment and authorize that my insurance benefits for covered services be paid directly to Texoma Physicians Group PLLC. I understand that I am financially responsible for any balance or service not covered by my insurance company. I authorize the Group and/or the insurance company to release any information required to process my claim. I also authorize a copy of this Consent to be used in lieu of the original. I further authorize the release of private health information to other providers involved in my child's care.

Signature _____ Name _____

Date _____