# CHILDREN & TEENS MEDICAL CENTER
## PATIENT INFORMATION

**PATIENT Name**: ______________________________ Date of Birth: ______________
← ***(Please see back page to list additional Siblings)*** →

Address: ____________________________________________

City: ______________________ State: __________ Zip: ______________

Primary Phone #: ____________________ Cell - Home    PATIENT SEX: Male  Female

MOTHERS' name: ______________________    FATHERS name: ______________________

DOB: ______________________    DOB: ______________________

*Address:* ______________________ *(If different from patients)*    *Address:* ______________________ *(If different from patients)*

*City:* ______________________    *City:* ______________________

*State & Zip Code:* ______________________    *State & Zip Code:* ______________________

*Mothers Phone #:* ______________________    *Fathers Phone #:* ______________________

*Employer:* ______________________    *Employer:* ______________________

*Employer phone:* ______________________    *Employer phone:* ______________________

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**INSURANCE INFORMATION:** ***Is this Market Place (Obama care) Insurance? YES NO (please circle)***

| **Primary Insurance:** | **Secondary Insurance:** |
|---|---|
| Insurance Co. Name ______________ | Insurance Co. Name ______________ |
| Ins. Co. Address ______________ | Ins. Co. Address ______________ |
| City, State, Zip ______________ | City, State, Zip ______________ |
| Ins. Co. Phone ______________ | Ins. Co. Phone ______________ |
| Policy # __________ Group # __________ | Policy # __________ Group # __________ |
| Policy Holder Name ______________ | Policy Holder Name ______________ |
| Policy Holder: DOB: __________ Sex: M F | Policy Holder: DOB: __________ Sex: M F |
| Policy Holders SSN # ______________ | Policy Holders SSN #______________ |
| Employer______________ | Employer______________ |

***If my child is a recipient of Medicaid insurance,*** *I/we acknowledge that we DO NOT have any other insurance coverage as primary and/or secondary. Failure to report other insurance coverage and a balance occurs; I agree to and understand that I may be responsible for the balance of all charges.*

***Signature:*** ______________________    ***Date:***

Mother's Email: ______________________
Father's Email: ______________________

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## PATIENT INFORMATION

Pharmacy Name: ________________________________________ Telephone # ______________________________

Pharmacy Address/City: ____________________________________________________________________________

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**Ethnicity:**

[ ] Hispanic or Latin
[ ] Not Hispanic or Latin
[ ] Refuse to Report

**Race:**

[ ] American Indian or Alaska Native
[ ] Native Hawaiian or Other Pacific Islander
[ ] White or Caucasian
[ ] Other Race
[ ] Unreported/Refuse to Report
[ ] Asian
[ ] Black or African American
[ ] Hispanic
[ ] Other Pacific Islander

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**Siblings that are patients:** **(If on Medicaid list policy if different on front page)**

Name ________________________________M / F DOB ____________ Medicaid ID#: ____________________

Name ________________________________M / F DOB ____________ Medicaid ID#: ____________________

Name ________________________________M / F DOB ____________ Medicaid ID#: ____________________

Name ________________________________ M / F DOB ____________ Medicaid ID#: ____________________

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**Nearest relative or Emergency Contact (Other than parents):**

Name ____________________________________________________________________________________

Address/City/State/Zip: ______________________________________________________________________

Phone ___________________________________________________________________________________

Relationship to patient: _______________________________________________________________________

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AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician/clinic to release any information or copies from my child/ children medical record to insurance companies, third party payers, or authorized agents; or claims review organizations in order to process a claim for payment on behalf of my child/children.

AUTHORIZATION TO PAY: I hereby authorize payment of medical benefits sent directly to Children & Teens Medical Center Corporation, physicians, or supplier of CTMC services rendered. I understand that I am financially responsible for the charges not covered by insurance.

X ________________________________ ___________________ ________________________

Signature of Parent/Guardian/Custodian/Non-Custodian Date