CHILDREN & TEENS MEDICAL CENTER
2015 NEW PATIENT INFORMATION

PATIENT name: _____ Date of Birth: _____
(***Please refer to back page for Siblings***)

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Cell - Home SEX: Male Female

MOTHERS' name: _____ FATHERS name: _____

DOB: _____ DOB: _____

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

City: _____ City: _____

State & Zip Code: _____ State & Zip Code: _____

Phone #:_____ Phone #: _____

Employer: _____ Employer: _____

Employer phone: _____ Employer phone: _____

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INSURANCE INFORMATION: ***Is this Market Place insurance? YES NO***

Primary Insurance:

Insurance Co. Name _____

Ins. Co. Address _____

City, State, Zip _____

Ins. Co. Phone _____

Policy # _____ Group # _____

Policy Holder Name _____

Policy Holder: DOB: _____ Sex: M F

Identifying SSN # _____

Employer_____

Secondary Insurance:

Insurance Co. Name _____

Ins. Co. Address _____

City, State, Zip _____

Ins. Co. Phone _____

Policy # _____ Group # _____

Policy Holder Name _____

Policy Holder: DOB: _____ Sex: M F

Identifying SSN #_____

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: _____

Mother's Email: _____
Father's Email: _____

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Pharmacy Name: _____ Telephone # _____

Pharmacy Address/City: _____

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Ethnicity: (circle one) Hispanic or Latin Not Hispanic or Latin Refuse to Report

Race:

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

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Siblings:

Name _____ M / F DOB _____

Name _____ M / F DOB _____

Name _____ M / F DOB _____

Name _____ M / F DOB _____

****

Nearest relative or Emergency Contact:

Name _____

Address _____

Phone _____

Relationship _____

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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