TOTS N TEENS PEDIATRICS

EVERY CHILD IS SPECIAL HERE

NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

First Name ____ M.I. ____ Last Name ____ Date of Birth ___/___/___

Home Phone # ___/___/___ Gender: Male Female Social Security # ___/___/___ Ethnicity ____

Address ____ City ____ State ____ Zip ____

FATHER INFORMATION

First Name ____ M.I. ____ Last Name ____ Date of Birth ___/___/___

Primary Phone # ___/___/___ Gender: Male Female Social Security # ___/___/___ Ethnicity ____

Address ____ City ____ State ____ Zip ____

Employer ____ Occupation ____ Work Phone # ___/___/___

MOTHER INFORMATION

First Name ____ M.I. ____ Last Name ____ Date of Birth ___/___/___

Primary Phone # ___/___/___ Gender: Male Female Social Security # ___/___/___ Ethnicity ____

Address ____ City ____ State ____ Zip ____

Employer ____ Occupation ____ Work Phone # ___/___/___

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PRIMARY INSURANCE INFORMATION

______________________ Primary Insurance Company ____/____/____ Phone # ____________ ID # ____/____/____ Effective Date

______________________ Address __________ City ______ State ________ Zip

__________ Group # __________ Group Name ______________ Subscriber First Name ____ M.I. ______________ Subscriber Last Name

____/____/____ Date of Birth ____/____/____ Phone # ______________ Relationship to Patient Guarantor: Yes No

SECONDARY INSURANCE INFORMATION

______________________ Secondary Insurance Company ____/____/____ Phone # ____________ ID # ____/____/____ Effective Date

______________________ Address __________ City ______ State ________ Zip

__________ Group # __________ Group Name ______________ Subscriber First Name ____ M.I. ______________ Subscriber Last Name

____/____/____ Date of Birth ____/____/____ Phone # ______________ Relationship to Patient Guarantor: Yes No

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT)

______________ First Name ____ M.I. ______________ Last Name ____/____/____ Date of Birth

____/____/____ Home Phone # Gender: Male Female ____/____/____ Social Security # ______________ Relationship to Patient

______________________ Address __________ City ______ State ________ Zip

Tel: (919) 362-7155
3434 Kildaire Farm Rd, Ste # 124, Cary, NC 27518

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SIBLING INFORMATION

First Name	M.I.	Last Name	Date of Birth
____________________	_____	____________________	_____/_____/______
____________________	_____	____________________	_____/_____/______
____________________	_____	____________________	_____/_____/______

AUTHORIZATIONs

- In the absence of the parent/legal guardian, I give the following person(s) permission to seek treatment for my child/children.
- I also realize that the person with my child may have access to pertinent protected health information if medically necessary.

This authorization will be valid for one year from the date listed below.

Person Name	Phone #	Relationship to Patient
______________________________	_____/_____/_____	____________________
______________________________	_____/_____/_____	____________________

______________________________ _____/_____/_____
Signature of Parent / Guardian Date

- I, the patient/parent/guardian give Tots N Teens Pediatrics permission to release information to my daycare/school upon request. Ex: Immunization record, dispensing of medication, and or absentee note due to appointment.

______________________________ _____/_____/_____
Signature of Patient / Parent / Guardian Date

- I understand that payment in full is expected at the time of service. However, in the event that Tots N Teens Pediatrics PLLC files claims on my behalf I authorize all benefits to be paid directly to Tots N Teens Pediatrics. Any charges not covered by insurance will be my responsibility. I authorize Tots N Teens Pediatrics PLLC and/or the rendering physician(s) to release all information required by my insurance company to file for medical benefits.

______________________________ _____/_____/_____
Signature of Parent / Guardian Date

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