WELCOME TO OUR PRACTICE

PLEASE FILL OUT ALL INFORMATION: Patient's First & Last Name (Please include all sibling's in our practice)

Name: ________________________ **DOB** ____/___/_____ **Sex** ______
Name: ________________________ **DOB** ____/____/____ **Sex** ______
Name: ________________________ **DOB** ____/____/_____ **Sex** ______
Name: ________________________ **DOB** ____/____/_____ **Sex** ______
Name: ________________________ **DOB** ____/____/_____ **Sex** ______

Mother/Legal Guardian

Name: ________________________
Cell Phone ________________________
Home Phone ________________________
Work Phone ________________________
Email ________________________ ☐ Consent for THH Newsletter
Mother's DOB ________________________

Father/Legal Guardian

Name: ________________________
Cell Phone ________________________
Home Phone ________________________
Work Phone ________________________
Email ________________________ ☐ Consent for THH Newsletter
Father's DOB ________________________

Patient's Contact Information (Patients 18 Years or Older Only)

Name: ________________________
Cell Phone ________________________
Home Phone ________________________
Work Phone ________________________
Email ________________________ ☐ Consent for THH Newsletter

If 18 y/o or older please check here if you allow THH to discuss your medical information with your parents __________
Please list any others with whom you grant us permission to discuss your medical information: __________________

Residential Address:

Home Address ____

City ________________ State ______________ Zip Code ____________

IS THERE A LEGAL CUSTODY AGREEMENT FOR ANY CHILD MENTIONED ON THIS FORM? Yes ___ No ___
IF YES, THAT AGREEMENT MUST BE ATTACHED TO THIS FORM IN ORDER FOR SERVICES TO BE RENDERED

By supplying my cell phone number, home phone number, email address and other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my health care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balance due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voicemail, answering system, or with another individual, if I am unavailable at the number provided by me. I consent to a THH electronic newsletter being sent to the email addresses listed above that are affirmed with a marking in the corresponding box.

________________________________ ________________________

Signature of patient or parent if patient is a minor **Date**

PRIMARY INSURANCE INFORMATION

Policy Holder's Name_______________________________ **Relationship to Patient**__________________
Policy Holder's DOB____/___/____ **Soc. Sec. #**_______/_____/_______
Name of Insurance Co.__________________________ **Name of Employer**__________________________
Insurance I.D.#________________________________ **Group #**__________________________________
Ins. Claims Address____
City, State, Zipcode____
Copay $_______ **Effective Date**____/___/____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name_______________________________ **Relationship to Patient**_______________________
Holder's DOB____/___/_____ **Soc. Sec. #**_______/_____/_______
Name of Insurance Co.__________________________ **Name of Employer**________________________________
Insurance I.D.#________________________________ **Group #**_______________________________________
Ins. Claims Address____
City, State, Zipcode____
Copay $_______ **Effective Date**____/___/____

Billing Address (Address of person responsible for payment):

Please check here if same as Residential Address _____________

Home Address ____
City _____________________________ State _________________ Zip code _____________

Authorization & Release

We require a full 24-hour notice prior to your appointment time should you need to cancel. There will be a **$50** charge for a cancellation without proper notice, or if a scheduled appointment is missed. This charge will not be covered by your insurance and will be your responsibility. Additional service codes will be billed for care provided on Weekends or after 6:00 pm Weekdays.

I authorize this doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____ ____

Signature of patient or parent if patient is a minor **Date**