THH PEDIATRICS
TENDER HEARTS & HANDS

Welcome to our Practice

PLEASE COMPLETE ALL SECTIONS OF THIS FORM.

Patient's First and Last Name (Please include all siblings in our practice. **SEPARATE FORMS REQUIRED FOR SIBLINGS WITH DIFFERENT INSURANCE AND/OR PARENT INFORMATION. FORM MUST BE COMPLETED BY PARENT/LEGAL GUARDIAN ONLY!**)

Name: _____ DOB: / / Sex: _____

Name: _____ DOB: / / Sex: _____

Name: _____ DOB: / / Sex: _____

Home Address: _____

City / State / Zip Code: _____

MOTHER/LEGAL GUARDIAN

Name: _____

Primary phone: _____ **H C W** (Circle one)

Secondary phone: _____ **H C W** (Circle one)

Soc. Sec. #: _____

Driver's Lic. #: _____

DOB: / /

FATHER/LEGAL GUARDIAN

Name: _____

Primary phone: _____ **H C W** (Circle one)

Secondary phone: _____ **H C W** (Circle one)

Soc. Sec. #: _____

Driver's Lic. #: _____

DOB: / /

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

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 / Zip Code: _____

Copay $: _____ Effective Date: / /

SECONDARY 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 / Zip Code: _____

Copay $: _____ Effective Date: / /

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 prior notice, or if a scheduled appointment is missed. This charge will not be covered by your insurance and will be your responsibility.

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 their party payers and/or 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 dependants. **I understand that if this form is not completed in full, I will be responsible for the entire balance due for services as insurance can not be billed without this information.**

_____ _____

Signature of patient or parent/legal guardian if patient is a minor Date