TAX ID: 22-3845047

TOUCHPOINT PEDIATRICS, P.A.

PATIENT ID:

This form must be updated every 12 months

PATIENT REGISTRATION

PATIENT INFORMATION:

LAST NAME | FIRST NAME | MI | DOB | SEX

NAMES OF SIBLINGS/DOB:

ADDRESS | CITY | COUNTY | STATE | ZIP

PRIMARY LANGUAGE | SECONDARY LANGUAGE

ETHNICITY: ☐ HISPANIC OR LATINO ☐ UNKNOWN ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO PROVIDE

RACE: ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK ☐ WHITE ☐ UNKNOWN ☐ HAWAIIAN NATIVE OR PACIFIC ISLANDER ☐ DECLINE TO PROVIDE

PARENT/GUARDIAN 1 INFORMATION: RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER ☐ OTHER

LAST NAME | FIRST NAME | MI | ADDRESS | CITY, STATE, ZIP

EMAIL | DOB | ☐M ☐F SEX | EMPLOYER

PRIMARY PHONE ☐ CELL ☐ HOME ☐ WORK | SECONDARY PHONE ☐ CELL ☐ HOME ☐ WORK

PARENT/GUARDIAN 2 INFORMATION: RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER ☐ OTHER

LAST NAME | FIRST NAME | MI | ADDRESS | CITY, STATE, ZIP

EMAIL | DOB | ☐M ☐F SEX | EMPLOYER

PRIMARY PHONE ☐ CELL ☐ HOME ☐ WORK | SECONDARY PHONE ☐ CELL ☐ HOME ☐ WORK

PRIMARY INSURANCE INFORMATION: INSURANCE COMPANY:

NAME OF INSURED: ☐PARENT 1 ☐ PARENT 2

ADDRESS | CITY, STATE, ZIP | PHONE

ID NUMBER | GROUP NAME/NUMBER | PLAN NUMBER | EFFECTIVE DATE | COPAY

EMERGENCY CONTACT:

ALTERNATE EMERGENCY CONTACT | HOME PHONE | CELL PHONE | RELATIONSHIP

HOW DID YOU FIND OUT ABOUT THE PRACTICE?

☐ WORD OF MOUTH (FRIEND) ☐ ADVERTISING ☐ OTHER

Acknowledgement of Financial Responsibility and Assignment of Insurance Benefits

I hereby authorize direct payment of benefits to Dr. Jennifer Shaw-Brachfeld / Touchpoint Pediatrics, P.A. for services rendered by her in person or under her supervision. I understand that I am financially responsible for all services rendered that are considered out of network or any balance that is not covered by my insurance carrier. I authorize the use of this signature on all insurance submissions.

I authorize Touchpoint Pediatrics, P.A. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I certify that the information given by me in applying for payment on behalf of myself or my dependents is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments should be valid as the original.

For your convenience, if you would like us to keep your credit card information securely, please select "Yes" if not , select "No" ☐ Yes ☐ No

PARENT/GUARDIAN NAME (PLEASE PRINT) | PARENT/GUARDIAN SIGNATURE | DATE

REV 4.8.18

Please Note: Co-pay is due at time of service and your insurance card must be presented prior to each visit

SIGN UP FOR THE PATIENT PORTAL TODAY!