



Town & Country Pediatrics

Patient Name: _____
Last First Middle Initial

Preferred name _____ Date of Birth _____ Sex _____

Street Address _____ City _____ State _____ Zip _____

Primary Phone # _____ Mobile Home Work May we leave a message? Y N

Secondary Phone # _____ Mobile Home Work May we leave a message? Y N

Preferred Language _____ Do you need an interpreter? Y N

Ethnicity: Hispanic Not Hispanic Other Decline to disclose

Race: American Indian or Alaskan Native Asian African American Caucasian
 Other Native Hawaiian or Other Pacific Islander Decline to Disclose

Religion _____

Parent/Legal Guardian Information:

Name _____ Birthdate _____ Relationship _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Email _____

Preferred Method of Contact: Mail Phone Email

Name _____ Birthdate _____ Relationship _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Email _____

Preferred Method of Contact: Mail Phone Email

Who referred you? Insurance Friend/Family (please name): _____

Obstetrician (please name): _____ Other: _____

Preferred Pharmacy Name _____ Phone # _____

Street Address _____ City _____ State _____ Zip _____



Emergency Contact (other than parent)

Last Name _____ First Name _____
Primary Phone # _____ Mobile Home Work May we leave a message? _____
Language _____ Does this contact require an interpreter? _____
Relationship to patient _____

Guarantor Information

Last Name _____ First Name _____ Birthdate _____
Sex _____ Phone _____
Street Address _____ City _____ State _____ Zip _____
Employer Name _____ Occupation _____
Street Address _____ City _____ State _____ Phone # _____

Health Coverage Details (If insurance card not present)

1. Primary Coverage _____ Auth Phone # _____

Claim Address _____ City _____ State _____ Zip _____
Name on Card: _____
Member relationship to the subscriber: _____ Member ID #: _____ Effective Date: _____
Subscriber's Last Name _____ First Name _____ Sex _____ DOB _____
Street Address _____ City _____ State _____ Zip _____
Subscriber ID #: _____ Group #: _____ Group Name: _____

2. Secondary Coverage _____ Auth Phone # _____

Claim Address _____ City _____ State _____ Zip _____
Name on Card: _____
Member relationship to the subscriber: _____ Member ID #: _____ Effective Date: _____
Subscriber's Last Name _____ First Name _____ Sex _____ DOB _____
Street Address _____ City _____ State _____ Zip _____
Subscriber ID #: _____ Group #: _____ Group Name: _____

Printed Name: _____

Signature: _____ Date: _____