# TOMAHAWK FARM PEDIATRICS PC

Patient Registration

*Child's Name* _____ *D.O.B.* _____ *Sex* _____

*Child's Name* _____ *D.O.B.* _____ *Sex* _____

*Child's Name* _____ *D.O.B.* _____ *Sex* _____

*Child's Name* _____ *D.O.B.* _____ *Sex* _____

**Contact 1:** *Name* _____ *Relation to Patient* _____
*Lives with Patient?* Yes / No *D.O.B.* _____ / _____ / _____ *Social Security #* _____
*Address* _____
*Home Phone* _____ *Cell Phone*_____ *Work Phone* _____
*Home Email* _____ *Work Email* _____
*Employer* _____ *Occupation* _____

**Contact 2:** *Name* _____ *Relation to Patient* _____
*Lives with Patient?* Yes / No *D.O.B.* _____ / _____ / _____ *Social Security #* _____
*Address* _____ If same, check box: ❑
*Home Phone* _____ *Cell Phone*_____ *Work Phone* _____
*Home Email* _____ *Work Email* _____
*Employer* _____ *Occupation* _____

*Who should receive billing statements?* _____

***If parents are divorced or separated, please fill out this section:***
*Who has custody?* _____
*Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?* Yes / No
*If yes, please explain and provide a copy of any legal paperwork that supports this restriction.*
_____

**Emergency Contacts,** <u>other than parents:</u> Name & Relationship

1: _____ *Phone:*_____
2: _____ *Phone:*_____

**<u>Authorization of Treatment and Assignment of Benefits:</u>**
I authorize Tomahawk Farm Pediatrics to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to Tomahawk Farm Pediatrics for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Tomahawk Farm Pediatrics for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all copayments and any charges not covered under my insurance benefits. I also understand that I am responsible for advising Tomahawk Farm Pediatrics of any and all changes to my insurance.

Signature _____ Relationship _____ Date _____