Today's Date_____

TOWN CENTER PEDIATRICS FAMILY REGISTRATION FORM

I give consent to scan this form into the electronic medical record of each child listed

Signature_____Relationship to child (ren)_____

Last Name:_____First Name:_____MI:___DOB:_____Sex:___Race:____

Last Name:_____First Name:_____MI:___DOB:_____Sex:___Race:____

Last Name:_____First Name:_____MI:___DOB:_____Sex:___Race:____

Last Name:_____First Name:_____MI:___DOB:_____Sex:___Race:____

Patient's Mailing Address_____Apt#_____

City_____State_____Zip_____Primary Phone #_____

Parent's Name_____Date of Birth_____

Address (If different from child's)_____

Hm Phone_____Wk Phone_____Cell Phone_____TXDL#_____

Employer/Occupation_____Email Address_____

Parent's Name_____Date of Birth_____

Address (If different from child's)_____

Hm Phone_____Wk Phone_____Cell Phone_____TXDL#_____

Employer/Occupation_____Email Address_____

Emergency Contact_____Phone_____

Relationship to patient_____

Please bring a copy of your child's insurance card(s) to ALL visits. In order for us to file your insurance correctly, please complete the following:

Primary Insurance Name_____PPO HMO POS EPO (circle one)

Policy #_____Group #_____Phone #_____

Insured's Name_____DOB_____Relationship_____

Do you have secondary insurance? YES or NO (circle one)

Who referred you to our practice?_____