TLC Pediatrics of Amarillo

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Were Compassion, Caring and Dedication Come First

Registration Form

Patient and Family Information

Patient Last Name: First: Middle:

SEX: ☐ M ☐ F

DOB: ____ /____ /_____

S.S. no: _____ -____- _____

Parental Information

Mother Legal Guardian

Last Name: First: Middle:

DOB: ____ / ____ / _____ SS no: _____-_____-_____

Mailing Address: _____

City State Zip

Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Email: _____

Employer: _____

Occupation: _____

Marital Status:
Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Father Legal Guardian

Last Name: First: Middle:

DOB: ____ / ____ / _____ SS no: _____-_____-_____

Mailing Address: _____

City State Zip

Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Email: _____

Employer: _____

Occupation: _____

Marital Status:
Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Has Custody? Both ☐ Father ☐ Mother ☐ Other ☐ _____

Party Responsible for Payment: Mother ☐ Father ☐ Guardian ☐ Other ☐ _____

In Case of Emergency

Names of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone no:	Work or Cell Phone no:
1.		(___) ____ - _____	(___) ____ - _____
2.		(___) ____ - _____	(___) ____ - _____
List individuals who you can give consent to treat your child:	**Relationship to Patient:**	**Home Phone no:**	**Work or Cell Phone no:**
1.		(___) ____ - _____	(___) ____ - _____
2.		(___) ____ - _____	(___) ____ - _____

Authorization Notes

The above information is true to the best of knowledge. I authorize my insurance benefits be paid directly to TLC Pediatrics of Amarillo. I understand that my insurance carrier may pay less than the actual bill of service. I agree to be financially responsible for any balance and for all services rendered. I authorize TLC Pediatrics to release information including diagnosis and, records of treatment or examinations during the period of such care to third party payers and or other health practitioners.

Patient/ Parent/ Guardian: _____ Date: _____ / _____ / _____