Today's Date_____/_____/_______

Arrival Time: __________AM__PM__ **Appointment Time: __________ AM__PM__**

I. Patient(s) Information:

Child's Name: ____ Date of Birth: ______/_______/_________

Child's Name: ____ Date of Birth: ______/_______/_________

Reason for today's visit: ____

II. Parent/Guardian Contact Information

Name: ______________________________ Street Address: ___________________________Apt# __________

City: ______________________________ State: ________ Zip: ______________

Cell Phone _____________________ Work Phone: _____________________ Email: ____________________

Emergency Contact: ____ Phone: _____________________________

III. Insurance Information

Has your insurance changed since your last visit? [Circle One] [Yes] or [No] or [First Visit]

Primary Insurance: _____________________ Secondary Insurance: ______________________

Primary Plan ID # ______________________ Group # _____________ Policy Holder DOB: ________________

Secondary Plan ID # ____________________ Group # _____________ Policy Holder DOB: ________________

Primary Effective Date: _____/_______/_______ Secondary Effective Date: _____/_______/_______

IV. Authorization

I have read all of the above information and have completed it to the best of my knowledge. I will notify staff of any changes in my insurance status or contact information while under TP care. I hereby authorize Tenney Pediatric & Adolescent Medicine, LLC [TPM] to release medical or other information to my insurance companies necessary to process insurance claims related to this and other visits. I understand that I am responsible for any amount not covered by my insurance including copayments due at time of service.

I have read the above information and consent that it is correct to the best of my knowledge. By signing, I authorize Tenney Pediatric & Adolescent Medicine, LLC and its healthcare providers to render necessary treatment;

Signature ______________________________ Printed Name: ______________________________ Date: _______