

Pediatric Registration Form

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Patient Information:

Acct# _____

Name _____ Preferred Name _____ Birthdate _____
First Middle Last

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell or Other Phone _____

Patient Social Security # _____ E-mail Address _____

Sex: Male Female Mother's social security number (if patient is less than 1 year old) _____

Patient's School _____ School Phone Number _____

Father's Name _____ Employer _____ Employer Phone _____

Mother's Name _____ Employer _____ Employer Phone _____

How did you hear about us? _____

Emergency Contact _____ Relationship _____ Phone Number _____

List anyone who may seek or discuss medical treatment for patient in parental absence _____

For minors 14 thru 18 years of age: Do you give permission for patient to seek medical care alone? Yes No

Financial Responsibility: **Please complete with the name of the person responsible for the patient's bill.**

Responsible Party Name _____ Birthdate _____
First Middle Last

Address _____
(If different from above)

Telephone # _____ Social Security # _____ Relationship _____

Employer _____ Employer Phone # _____

Insurance Information: **Please provide a copy of your insurance card(s) at check in.**

Primary Insurance

Insurance Co _____

Name of Subscriber _____

Birthdate of Subscriber _____

Social Security Number of Subscriber _____

Patient Relationship to Insured :

Self Spouse Child Other

Secondary Insurance

Insurance Co _____

Name of Subscriber _____

Birthdate of Subscriber _____

Social Security Number of Subscriber _____

Patient Relationship to Insured:

Self Spouse Child Other

I hereby authorize Phillips Medical Group, P.C. to disclose any information necessary for the processing of my claims related to my treatment at Phillips Medical Group, P.C. I understand that this authorization extends to the treatment and furnishing a copy of all reports related to my treatment. The question of privacy between Phillips Medical Group, P.C., my treating physician and myself are waived with regards to the information contained in the records and reports furnished to my insurance carrier. I understand my insurance carrier may not cover and/or pay for services rendered, and I agree to be financially responsible for any services that are not covered by my insurance carrier.

Responsible Party Signature: _____ Relationship to Patient: _____ Date: _____