

# Patient Information Sheet

Date: \_\_\_\_\_

## Child Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_  
DOB: \_\_\_\_\_ M \_\_\_/F \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_  
Primary Pharmacy \_\_\_\_\_ Phone# \_\_\_\_\_  
Primary Pediatrician \_\_\_\_\_ Phone# \_\_\_\_\_

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## Child's Parent/Guardian

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_  
Employer/School \_\_\_\_\_ Email \_\_\_\_\_

## Child's Parent/Guardian

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_  
Employer/School \_\_\_\_\_ Email \_\_\_\_\_

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## Insurance Information

	Primary	Secondary
Name of Insurance		
Insurance ID		
Group # or Group Name		
Guarantor Name		
Relationship to Patient		

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*Total Access Pediatric Urgent Care LLC files primary insurance only for services provided to patients with managed care organizations in which we participate. Co-payments, co-insurance, non-covered services, and deductibles are the responsibility of the patient/guarantor and payable at the time of service. Managed care patients are billed for any remaining patient responsibility after claims have been processed by the insurance company. Proof of insurance is not a guarantee of payment. Patients without insurance or covered under an insurance plan that is "Out of Network", are financially responsible for all charges at the time of service or thereafter. In the event that payment for a service performed is erroneously denied by the insurance carrier, it is the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the two. It is also the responsibility of the patient to be aware of plan benefits and your right to appeal claims. Insurance contracts are subject to change. Provider directories produced by Managed Care plans may not provide the most current information regarding plan participation and therefore are not a guarantee of coverage.*

*By signing below, I accept the financial terms noted above and understand that I am financially responsible for all professional charges that my children may incur. I certify that the information contained in this form is true and correct. Furthermore, I understand it is my responsibility to present TAPUC with valid insurance, photo ID and demographic information at each visit.*

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_