TOTS N TEENS CLINICS
Patient Intake Form

Patient Name:

Last: ____ First: ______________________________________ MI: ___

Date of Birth: ____/____/_____ Social Security Number: ________________________ Sex: ☐ M ☐ F

Street Address: ______________________________ City: _________________ State: _____ ZIP: _______________

Home Phone: ____________________ Cell Phone: ________________ Alternate Phone: _____________________
May we leave confidential messages/test results on home answering machine or cell number? ☐ Yes ☐ No

Email Address: ____

Referred by: ____

Party Responsible for Payment of Medical Services:

Last: ____ First: ______________________________________ MI: ___

Relationship to Patient: __________________

Street Address: _____________________________ City: _______________________State: _____ ZIP: ___________

Home Phone: ____________________ Work Phone: _________________

Insurance Information:

Primary Insurance: __________________ Policy ID: ___________________Group Number: ____________________

Policy Holder Name: __________________ Insured Person's DOB___/___/____ Insured SSN: ___________________

Insured Person's Relationship to Patient: _________________

Secondary Insurance: __________________ Policy ID: ________________ Group Number: ____________________

Policy Holder Name: __________________ Insured Person's DOB___/___/____ Insured SSN: ___________________

Insured Person's Relationship to Patient: _________________

The following person(s) have permission to bring my child(ren) to doctor appointments. They may receive confidential medical information on above child.

Name: ______________________________________ Relationship: _________________ Phone: _______________
Name: ______________________________________ Relationship: _________________ Phone: _______________

- **I authorize Tots N Teens to treat my child**
- **I authorize Tots N Teens to release any medical information necessary to complete and process my insurance claims**
- **I attest that the above information is true and accurate, and understand falsification of said information is punished by law.**

Responsible Party Name: _________________________________ Relationship: ______________________________

Responsible Party Signature: ______________________________ Date: ____________________________________