Tiga Pediatrics

Tiga Pediatrics - New Patient Registration

Date: _____

Patient Name: _____ MI: _____ D.O.B: ____/____/_____

Gender: _____ Race: _____ Ethnicity: _____ S.S. #: _____

Home #: _____ Cell #: _____

Address: _____ Preferred Language: _____

_____

Email: _____ (For Patient Portal Access)

Responsible Party for Insurance:

Parent Name:_____ Parent D.O.B:____/____/____

Address:_____ S.S #:_____

_____

Telephome: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Tel #: _____

_____

Insurance Information:

Insurance Name: _____ Subscriber #: _____ Group#: _____

Insured Name: _____ Co-Pay: _____

Allergies or Serious Illnesses: _____

PLEASE HAND IN INSURANCE CARD, IMMUNIZATIONS AND ANY OTHER MEDICAL RECORDS TO FRONT DESK.