TAX ID: 22-3845047

TOUCHPOINT PEDIATRICS, P.A.

PATIENT ID:

This form must be updated every 12 months

PATIENT REGISTRATION

PATIENT INFORMATION:

LAST NAME | FIRST NAME | MI | DOB | ☐M ☐F SEX

NAMES OF SIBLINGS/DOB:

ADDRESS | CITY | COUNTY | STATE | ZIP

PRIMARY LANGUAGE | SECONDARY LANGUAGE

ETHNICITY: ☐ HISPANIC OR LATINO ☐ UNKNOWN ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO PROVIDE

RACE: ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK ☐ WHITE ☐ UNKNOWN ☐ HAWAIIAN NATIVE OR PACIFIC ISLANDER ☐ DECLINE TO PROVIDE

PARENT/GUARDIAN 1 INFORMATION:

RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER ☐ OTHER

LAST NAME | FIRST NAME | MI | ADDRESS | CITY, STATE, ZIP

EMAIL | DOB | ☐M ☐F SEX | EMPLOYER

PRIMARY PHONE ☐ CELL ☐ HOME ☐ WORK | SECONDARY PHONE ☐ CELL ☐ HOME ☐ WORK

PARENT/GUARDIAN 2 INFORMATION:

RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER ☐ OTHER

LAST NAME | FIRST NAME | MI | ADDRESS | CITY, STATE, ZIP

EMAIL | DOB | ☐M ☐F SEX | EMPLOYER

PRIMARY PHONE ☐ CELL ☐ HOME ☐ WORK | SECONDARY PHONE ☐ CELL ☐ HOME ☐ WORK

PRIMARY INSURANCE INFORMATION:

INSURANCE COMPANY:

NAME OF INSURED: ☐PARENT 1 ☐ PARENT 2

ADDRESS | CITY, STATE, ZIP | PHONE

ID NUMBER | GROUP NAME/NUMBER | PLAN NUMBER | EFFECTIVE DATE | COPAY

EMERGENCY CONTACT:

ALTERNATE EMERGENCY CONTACT | HOME PHONE | CELL PHONE | RELATIONSHIP

HOW DID YOU FIND OUT ABOUT THE PRACTICE?

☐ WORD OF MOUTH (FRIEND) ☐ ADVERTISING ☐ OTHER

Acknowledgement of Financial Responsibility and Assignment of Insurance Benefits

I hereby authorize direct payment of benefits to Dr. Jennifer Shaw-Brachfeld / Touchpoint Pediatrics, P.A. for services rendered by her in person or under her supervision. I understand that I am financially responsible for all services rendered that are considered out of network or any balance that is not covered by my insurance carrier. I authorize the use of this signature on all insurance submissions.

I authorize Touchpoint Pediatrics, P.A. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I certify that the information given by me in applying for payment on behalf of myself or my dependents is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments should be valid as the original.

For your convenience, if you would like us to keep your credit card information securely, please select "Yes" if not , select "No" ☐ Yes ☐ No

PARENT/GUARDIAN NAME (PLEASE PRINT) | PARENT/GUARDIAN SIGNATURE | DATE

REV 5.4.17

Please Note: Co-pay is due at time of service and your insurance card must be presented prior to each visit

SIGN UP FOR THE PATIENT PORTAL TODAY!

TOUCHPOINT PEDIATRICS, P.A.

Primary Contact Preferences

Patient Name: ____ **DOB:** _______________

Sibling(s) Name:______________________________________ **DOB:** _______________

Sibling(s) Name:______________________________________ **DOB:** _______________

What is your preferred method of contact?

(*Please choose one method for each category*)

General Notices, Appointments, Recalls and Reminders (*Inclement Weather, Office Announcements etc.)*

☐ Home Email

or

☐ Text to Cell

☐ I do not wish to be contacted electronically. Please contact me at the following number for all office/patient related issues.

Telephone: ____

Our system requires (1) primary email address and (1) primary cell phone number to be listed per family

Primary Name: ____

Primary Cell Phone: ____

Primary Email Address:______________________________________

I approve the above method of contact from Touchpoint Pediatrics.

______________________________	______________________________	______________
Printed Primary Parent/Guardian Name	*Signature Primary Parent/Guardian*	*Date*

17 Watchung Avenue • Chatham, NJ 07928 • Phone 973.665.0900 • Fax 973.665.0901