

TCN Return Patient up date Form

Robert Chudnow, MD ___ Anthony Riela, MD ___ Gerald So, MD ___ Patricia Mirles, MD ___

Patient Full Legal Name _____ DOB _____ Home Phone _____

Primary Care Physician: _____ Address: _____

Office #: _____ Fax #: _____

Parent/Guardian Information: ___ Stepparent ___ Grandparent ___ Sibling ___ Nanny

Father/Other () _____ Mother/Other () _____

Name: _____ Name: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

DOB: _____ SS#: _____ DOB: _____ SS#: _____

Home #: _____ Cell #: _____ Home #: _____ Cell #: _____

E-Mail Address: _____ E-Mail Address: _____

Employer: _____ Employer: _____

Work #: _____ Work #: _____

Primary Residence of Patient: _____

Custody Information: _____

Important/Emergency Contacts: _____

Important/Emergency Contacts: _____

Insurance Information:

Insurance Company: _____ Customer Service #: _____

Insurance Claims Mailing Address: _____

Policy Holder: _____ Contact #: _____

DOB: _____ Address: _____

Member ID #: _____ Group #: _____

I authorize TCN and their agencies to contact me by the following method(s), Please check all that apply:

- | | | | | |
|------------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Home Number | <input type="checkbox"/> Mom's Cell | <input type="checkbox"/> Mom's Work | <input type="checkbox"/> Mom's E-mail | <input type="checkbox"/> Emergency Contact; when necessary |
| <input type="checkbox"/> Home Number | <input type="checkbox"/> Dad's Cell | <input type="checkbox"/> Dad's Work | <input type="checkbox"/> Dad's E-mail | |
| <input type="checkbox"/> Ok to leave message with detailed information | <input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> Ok to E-mail detailed information, (patient information) | | |

I hereby assign, and set over to TEXAS CHILD NEUROLOGY all of my rights, title, and interest to my MEDICAL reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoking said authorization give written notice. **I understand that I am financially responsible for all charges whether or not they are covered by insurance.**

Patient /Parent/Guardian signature: _____ Date: _____

Patient Name: _____ DOB: _____