



TLC Pediatrics, P.A.

“Where Kids Come First”

*Daniel J. Moulton, MD, FAAP Jenna O'Brien, DO, FAAP
Mystii Nekuza, RN, MS, CPNP Chandra Garvey, RN, MS, CPNP*

1105 N Central Expressway North, Ste 250, Allen, Texas 75013
Office (972) 747-KIDS (5437) Fax (972) 747-5497

WWW.TLCPEDI.COM

Patient Information:

Name: _____ Nickname: _____

Date of Birth: ____/____/____ Child's Sex: Male Female

Parents/Guardians:

Mother: _____ D.O.B. ____/____/____

Mother's SSN: _____ Driver's License: _____

Father: _____ D.O.B. ____/____/____

Father's SSN: _____ Driver's License: _____

Address: _____
Street Number/Po Box City Zip code

Home Phone: (____) _____ - _____ Email Address: _____

Mother's Cell Phone: _____ Father's Cell Phone: _____

Mother's Employer _____ Wk Phone: _____

Father's Employer _____ Wk Phone: _____

How did you hear about our clinic: _____

Insurance Information:

Subscriber Name: _____ SSN: _____

Insurance Company: _____ Policy#: _____

Group#: _____ Co pay: _____ Type: HMO PPO POS EPO

If your insurance is an HMO or POS, have then been notified that we are your PCP? YES NO

- Your child's visit **may not** be covered by your HMO/POS if we are not listed as the PCP **prior** to the visit.

Emergency Contact:

Name: _____ Relationship: _____

Phone numbers: _____ Alt: _____

Siblings:

1. Name: _____ DOB: _____ Sex: Male Female

2. Name: _____ DOB: _____ Sex: Male Female

3. Name: _____ DOB: _____ Sex: Male Female

4. Name: _____ DOB: _____ Sex: Male Female

5. Name: _____ DOB: _____ Sex: Male Female

Automatic Payment Plan:

As a convenience to our patients, we offer the option to place a credit card on file for easy payment processing. Co-payments will be charged on the date of service and deductibles and co-insurance amount will be charged after payments from your insurance company. Should your deductible or co-insurance amount be over \$150.00 you will be contacted by phone in order to give permission for credit card processing. Receipts will be mailed to you following any credit card transactions. Your credit card information is kept secure and confidential. If you would like to take advantage of this option please provide us with the following information.

MC/ Visa/ Discover #: _____

Exp Date ____/____/____ CVV _____

Check the box below that pertains to the option that you would like:

Please use my credit card for copayments only

Please use my credit card for copayments and to pay on any balances that I might have

I/We agree:

- To give TLC Pediatrics providers and staff permission to examine and treat my child.
- To authorize release of information to my insurance carrier for the purpose of processing claims and hereby assign medical insurance benefits to TLC Pediatrics and Daniel J. Moulton, MD.
- To pay for services rendered at the time of services. I understand that balances not paid at the time of service will be assessed a \$20 fee. Any past due amounts will receive a late fee of \$10.00 per monthly billing cycles. Should my account become delinquent, I agree to pay the necessary collection fees. This assignment will remain in effect until I cancelled by me in writing.

Signature

Date