TOTAL FAMILY CARE
Dr. Hylton Lightman, Medical Director

New Patient Registration

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ Primary *Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child 2: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ Primary *Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child 3: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ Primary *Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child 4: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ Primary *Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child 5: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ Primary *Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child 6: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ Primary *Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Mailing Address:

_____

(Street or PO Box) *(City)* *(State & Zip)*

Home Phone (_____) _____ - _____ Mobile Phone (_____) _____ - _____

Who lives at this household? _____

601 Jarvis Avenue Far Rockaway NY 11691
Office Phone 718-868-4808
www.totalfamilycaremd.com

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Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ Policy Holders SSN: _____

Insurance Carrier: _____

ID# _____ Group # _____

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____Policy Holders SSN:_____

Insurance Carrier: _____

ID# _____ *Group #* _____

Parent / Guardian Information:

Contact 1: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Home Phone: (____) _____ - _____*Cell Phone*: (____) _____ - _____

Work Phone: (____) _____ -_____

Home Email: _____

Work Email: _____

Employer: _____ *Occupation:* _____

TFC STAFF ONLY: Access to Patient Portal (MUST HAVE EMAIL) + MUST CHANGE Status to: Minor

How would you like to be contacted and notified (circle one):

Medical Issues:	Home Phone	Work Phone	Text to Cell	Home Email	Work Email
Appointment Reminders:	Home Phone	Work Phone	Text to Cell	Home Email	Work Email
Recall Notices:	Home Phone	Work Phone	Text to Cell	Home Email	Work Email
Billing Statements:	Text to Cell	Home Email	Work Email	Mail to Home	
General Practice Notices:	Home Email	Work Email	Mail to Home		
Patient Portal Notifications:	Text to Cell	Home Email	Work Email		

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Contact 2: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

TFC STAFF ONLY: Access to Patient Portal (MUST HAVE EMAIL) + MUST CHANGE Status to: Minor

If Contact 2 requires notifications and PORTAL ACCOUNT in addition to Contact 1 YOU MUST Complete Below

OTHERWISE ONLY Contact 1 will be notified for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications

How would you like to be contacted and notified (circle one):

Medical Issues:	Home Phone	Work Phone	Text to Cell	Home Email	Work Email
Appointment Reminders:	Home Phone	Work Phone	Text to Cell	Home Email	Work Email
Recall Notices:	Home Phone	Work Phone	Text to Cell	Home Email	Work Email
Billing Statements:	Text to Cell	Home Email	Work Email	Mail to Home	
General Practice Notices:	Home Email	Work Email	Mail to Home		
Patient Portal Notifications:	Text to Cell	Home Email	Work Email		

Additional Contact Questions: (circle each below)

Who should receive billing statements? Contact 1 or Contact 2

Receive Billing Statements Via: Text to Cell - Email Home - Email Work - Mail to Home

May all contacts have access to the patient's records electronically? Yes / No

Emergency Contacts (OTHER THAN PARENTS)

1: Name _____ Phone (___) _____ - _____

Alternative Phone (___) _____ - _____ Relationship _____

2: Name _____ Phone (___) _____ - _____

Alternative Phone (___) _____ - _____ Relationship _____

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Privacy Constraints (**Check ONE**):

_____ No Restrictions: okay to leave message, send email or send mail
_____ Restrictions: person to person with patient or guardian only
_____ Restrictions (explain) _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes / No**

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

I authorize the release of any medical information necessary to process claims and payments for Total Family Care of the 5 Towns and Rockaway, I fully understand that I am financially responsible for all charges and balances remaining from claims, including charges not covered or denied by my insurance. I have been offered a copy of the Notice of Privacy Practice (HIPPA)

Signature: _____ Date: _____

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