TLC Family Medical & Rehab Center

10205 W. Hillsborough Ave., Suite B, Tampa, Florida 33615
Phone: 813.884.2300 • Fax: 813.884.2390

11357 Countryway Boulevard, Tampa, Florida 33626
Phone: 813.925.8800 • Fax: 813.925.8840

Patient Registration Form

Welcome to our office. In order to serve you properly, we need the following information. All information is strictly confidential.

Date: ____________

Patient's Name: ____________ (Last) ____________ (First) ____________ (Middle) ____________ (Nickname)

Date of birth: ____________ [ ] Age

Sex: ☐M ☐F

Social Security #: [ ] [ ] [ ]

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Spouse ☐Guardian

Local Mailing Address: ____________

City: ____________ State: ______ Zip: ______

Alternate Mailing Address: ____________

City: ____________ State: ______ Zip: ______

Home Phone: ____________

Work Phone: ____________ Ext.: ______

Cell: ____________

E-mail: ____________

Name of Spouse/Parent: ____________ Phone: ____________

Address: ____________

Nearest Relative Name/Address: ____________

Relationship: ____________ Phone: ____________

Name of Person to notify if Emergency: ____________

Address: ____________ Phone: ____________

Patient Employment: ☐Employed ☐Retired ☐Self-Employed ☐Disabled ☐Unemployed ☐Other

Employer: ____________ Occupation: ____________

Address: ____________ Phone: ____________

Primary Insurance Name: ____________

ID#: ____________ Group#: ____________ Phone: ____________

Secondary Insurance Name: ____________

ID#: ____________ Group#: ____________ Phone: ____________

Worker's Compensation Company Name: ____________ D.O.A.: ____________

Insurance: ____________ Group#: ____________ Phone: ____________

Auto Insurance Name: ____________ D.O.A.: ____________

Policy#: ____________ Phone: ____________

Referral Information: ☐Walk-In ☐Internet ☐Phone Book ☐Ad ☐Radio

Referred by: ____________

Please present your insurance card(s) so that we may make copies for your records.