



Mecklenburg Medical Group
Carolinas HealthCare System

ORG# _____

MRN# _____

<i>Patient</i>	<i>Parent/Responsible Party- if different</i> Patient Relationship <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Legal Last Name	
Legal First Name, Middle	
Nick Name	
SSN:	
Date of Birth	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	

Address	
Apt/Bldg/Suite #	
City, State, Zip	
Home Phone:	
Mobile Phone:	
Email Address:	

Employer Name	
Address	
City, State, Zip	
Phone	

Emergency Contact	Reason for visit _____
Name	
Home Phone	
Work Phone	Who referred you? _____
Mobile Phone	Permission to leave voice mail @ primary phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No

Primary Insurance	Secondary Insurance
Insurance Company	
Primary Policyholder Name	
Primary Policyholder DOB	
Primary Policyholder Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

Primary Care Physician _____

If none, do you need help finding a Primary Care Physician? Yes No

How did you learn about us? (Check One) Employer Insurance Yellow Pages Advertisement Family/Friend Other _____

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: _____