



Patient Registration-Pediatric

<i>Patient</i>	<i>Parent/Responsible Party- if different</i> Patient Relationship <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Legal Last Name	
Legal First Name, Middle	
Nick Name	
SSN	
Date of Birth	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Child Lives With <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian	

<i>Mother / Guardian</i>	<i>Father / Guardian</i>
Name	
Date of Birth	
Address	
Apt/Bldg/Suite #	
City, State, Zip	

Home Phone	
Work Phone	
Mobile Phone	
Email Address	

Employer Name	
Address	
City, State, Zip	

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

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

<i>Primary Care Physician</i>	If none, do you need help finding a Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Person responsible for payment of bill: Mother Father Guardian or 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: _____