PATIENT UPDATE Carolina Pediatrics & Adolescent Care, pa

Patient Name: First_____Middle_____Last_____Suffix_____

Doctor of Record:_____

Gender: M F Birthdate: _____/_____/_____ Age:_____

INFORMATION TO BE UPDATED/CHANGED: (Please select the category of information to be revised and make corrections/changes as needed)

_____Patient Mailing Address

Primary Address		**Alternate Address**
Line 1_____	**Country**	Line 1_____
Line 2_____	_____	Line 2_____
City _____State_____ Zip_____		City _____State_____Zip_____

_____Guarantor Information

Patient's Relationship to Guarantor: Child Spouse Other Specify_____

Prefix:_____ First_____Middle_____ Guarantor #_____ Birthdate _____/_____/_____

Last_____ Suffix_____ SS#_____-_____-_____ Gender M F

CONTACT INFO

Line 1_____	**Country**	Home #_____ WK_____ Ext_____
Line 2_____	_____	Employer_____
City _____State_____ Zip_____		email:_____ Cell_____

_____Insurance Information

1. Plan Name: _____ Policy ID#_____ Group#_____
   Policy Owner_____ Relationship to Patient _____
   DOB:_____ SS#:_____
2. Plan Name: _____ Policy ID#_____ Group#_____
   Policy Owner_____ Relationship to Patient _____
   DOB:_____ SS#:_____

_____Additional Patient Data

Pharmacy Name:_____ Phone#_____

Address:_____ Fax# _____

_____Contacts/Communication Please add or delete

Name	Relationship	Emergency Contact	Release of Medical Records	Primary Contact	Legal Guardian	Resides With

(PLEASE READ CAREFULLY, INITIAL AND SIGN AS INDICATED)

I AUTHORIZE Carolina Pediatrics to render medical care to my child_____.

I AUTHORIZE Carolina Pediatrics to file my health insurance and ASSIGN any benefits payable to Carolina Pediatrics _____

I UNDERSTAND AND ACKNOWLEDGE that I am ultimately responsible for any fees incurred for services provided to my child(regardless of insurance status) . Patient responsibility amounts are due in full at the time services are provided. This may include but is not limited to co-payments, co-insurance or account balances._____

I UNDERSTAND AND ACKNOWLEDGE that if I do not have insurance, I am responsible for any fees incurred for services rendered._____

I AGREE and ACKNOWLEDGE that it is my responsibility to notify Carolina Pediatrics immediately of any change in my insurance ._____

Signature:_____ Relationship_____ Date:_____