Patient Registration Form
Carolina Pediatrics & Adolescent Care, PA

Patient Name: **First** _____ **MI** _____ **Last** _____ **Suffix**_____
Gender: M F **Birthdate:** _____/_____/_____ **Age:** _____ SSN: _____-_____-_____
Nickname: _____
Patient Primary Contact Phone Number: _____ **Alternate Phone Number:** _____
Patient Portal Set-Up (*only* Parent or Legal Guardian): Please provide your email address: _____

Patient Mailing Address

Patient's Primary Address		**Alternate Address**
Line 1_____	**Country**	Line 1_____
Line 2_____	_____	Line 2_____
City _____State_____ Zip_____		City _____State_____ Zip_____

Parent's Name (Legal Guardian): _____ **SSN#:** _____

Guarantor and Insurance Information (person responsible for the bill other than insurance company)

Who is Financial Responsible for Patient? Mother _____ Father: _____ Other: _____
Billing Address: _____
(Street) (City/State/Zip)

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

If your visit is due to automobile related incident, please notify the Receptionist.

Additional Patient Data

Marital Status:_____ Student: Yes___No___ Pharmacy Name:_____

Contacts/Communication: Please add or delete (circle to indicate)

Name	Relationship	Emergency Contact Y/N Phone #	Release of Medical Records	Primary Contact	Legal Guardian	Resides With
		Y N	Y N	Y N	Y N	Y N
		Y N	Y N	Y N	Y N	Y N
		Y N	Y N	Y N	Y N	Y N

If someone other than the birth parent has guardianship/custody, a copy of the court papers is required.

(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 ._____
Print Full Name: _____
Signature: _____ **Relationship**_____ **Date:** _____

Office Use Only:
Patient Account #: _____ Information Confirmed by: _____ Changes Completed by: _____ Patient Portal Set-up/Email Confirmed: _____

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