Carolina Pediatric Group
Patient Registration

Date_________

Please note: ALL insurances require that we have a copy of your card on file. Please bring your most recent card with you to <u>every</u> visit as you will be asked to present it. Well child visits will be rescheduled for a more convenient time if copay is not paid.

Child's Name ______________________________ DOB_____________ SS# ______________ Male__ Female__
Street Address____ City _________________Zip Code___________
Home Phone ______________________________
Child lives with: mother father grandparents aunt uncle guardian
Who is responsible for payment of medical services? _________________________________

May we leave detailed messages on an answering machine or voice mail? Yes No
(Such as appointment reminders, lab/test results, or referral appointments) Phone Number: ______________________
Would you like to receive information via email? Yes No Email Address: _________________________________

<u>Mother/Guardian Information</u>
Name: ____ Maiden Name: _________________________________
Date of Birth _______________ SS# _________________
Relationship to child: mother step-parent grandparent legal guardian
Address (if different): ____
Home Phone ______________________ Cell Phone ____________________ Work Phone ____________________
Occupation ____ Employer _____________________________

<u>Father/Guardian Information</u>
Name: ____ Date of birth________________ SS# _________________
Relationship to child: father step-parent grandparent legal guardian
Address (if different): ____
Work phone ______________________ Cell Phone ____________________ Home Phone _____________________
Occupation ____ Employer _______________________________

If either parent/guardian is active duty military, please provide the following information:
Unit: ______________________________________ Company Commander: _________________________________
Unit Phone Number: __________________________________

<u>Insurance Information</u>
Company Name: ________________________________ Policy ID: ______________________ Group ID: __________
Claims Address: ____
Phone Number: _________________________________ Policy Holder's Name: ______________________________

Does your child have and allergies to foods, medications, insects, other? If yes, give name and reaction
____
Any serious reactions to immunizations? If yes, which ones? ____

Please list persons (other than those above) who are allowed to authorize treatment:
Name: ____ Phone # _______________________________________
Name: ____ Phone # _______________________________________
Name: ____ Phone# ____

I authorize my insurance benefits to be paid directly to the above physicians/providers, realizing that I am responsible to pay non-covered services, and I also authorize the release of pertinent medical information to insurance carriers. This authorization shall be valid unless rescinded in writing by one of a later date.
Parent/Guardian signature: ____ Date:_________________________

Whom may we thank for referring you? ____