



PATIENT INFORMATION: MRN: _____ ORG MRN: _____

Patient's Legal Name (*Last, First, Middle*) _____ Preferred Name _____

Social Security Number _____ Date of Birth _____ Sex M F Home Phone Number _____

The child lives with:
 Mother Father Grandparent Guardian _____

Mother / Guardian's Name _____ Father / Guardian's Name _____

Date of Birth _____ Sex _____ S.S.N. _____ Date of Birth _____ Sex _____ S.S.N. _____

Street Address (*Required*) _____ Street Address (*Required*) _____

P.O. Box (*if applicable*) _____ P.O. Box Zip Code _____ P.O. Box (*if applicable*) _____ P.O. Box Zip Code _____

City _____ State _____ Zip (+4 if known) _____ City _____ State _____ Zip (+4 if known) _____

Home Phone _____ Cell Phone _____ Work Phone _____ Home Phone _____ Cell Phone _____ Work Phone _____

Fax Number _____ Fax Number _____

E-Mail Address: _____ E-Mail Address: _____

Employer Name: _____ Employer Name: _____

Employer Address: (*Start Address/P.O. Box*) _____ Employer Address: (*Start Address/P.O. Box*) _____

City _____ State _____ Zip (+4 of known) _____ City _____ State _____ Zip (+4 of known) _____

INSURANCE INFORMATION:

PRIMARY Name of Plan _____ **SECONDARY / SUPPLEMENTAL** Name of Plan _____

Claims Address (*Street Address/P.O. box*) _____ Claims Address (*Street Address/P.O. box*) _____

(City) _____ (State) _____ (Zip code) _____ (City) _____ (State) _____ (Zip code) _____

Phone Number _____ Phone Number _____

Patient Policy Number _____ Group Number _____ Patient Policy Number _____ Group Number _____

Subscriber Name (*if different from patient*): (*Last, First, MI*) _____ Subscriber Name (*if different from patient*): (*Last, First, MI*) _____

Subscriber Sex M F Subscriber Policy # _____ Subscriber Sex M F Subscriber Policy # _____

Guarantor Employer Name _____ Guarantor Employer Name _____

Effective Date _____ Expiration Date _____ Effective Date _____ Expiration Date _____

Copay Amount \$ _____ Relationship to child _____ Copay Amount \$ _____ Relationship to child _____

Plan Type: PPO HMO POS Other _____ Plan Type: PPO HMO POS Other _____

Person Responsible for Payment of Bill Mother Father Guardian or Other _____

EMERGENCY CONTACT: (Other than Mother or Father)

Name (<i>Last, First, Middle</i>)		Relationship
Home Phone Number	Work Phone Number	Cell Phone Number

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 compliant 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 _____ / _____ / _____

Office Use Only:

General Comment Section: