Carolinas Physicians Network
Carolinas HealthCare System

Pediatric
Patient Registration Form

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			**SECONDARY / SUPPLEMENTAL**		
Name of Plan			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 _____

PLEASE COMPLETE BACK OF FORM

EMERGENCY CONTACT: *(Other than Mother or Father)*

Name (***Last***, *First, Middle)*		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: