Carolinas HealthCare System

ORG# _____

MRN# _____

Patient Registration-Adult

	Patient	Parent/Responsible Party- if different Patient Relationship ☐ Child ☐ Spouse ☐ Other
Legal Last Name		
Legal First Name, Middle		
Nick Name		
SSN		
Date of Birth		
Sex	☐ Male ☐ Female ☐ Mother's Maiden Name _____	RACE: ☐ Black or African American ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Multicultural ☐ Asian ☐ Native American ☐ Other ☐ Unknown ☐ Decline
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow	
	ETHNIC ORIGIN: ☐ Hispanic ☐ Non-Hispanic ☐ Decline	Preferred Language: _____
Address		
Apt/Bldg/Suite #		
City, State, Zip		
Home Phone		
Work Phone		
Mobile Phone		
Email Address		
Employer Name		
Address		
City, State, Zip		

	Emergency Contact	
Name		Reason for visit _____
Home Phone		Who referred you? _____
Work Phone		Permission to leave voice mail @ primary phone number? ☐ Yes ☐ No
Mobile Phone		

	Primary Insurance	Secondary Insurance
Insurance Company		
Primary Policyholder Name		
Primary Policyholder DOB		
Primary Policyholder Sex	☐ Male ☐ Female	

Primary Care Physician _____

If none, do you need help finding a Primary Care Physician? ☐ Yes ☐ No

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 complaint 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: _____

Request for Treatment:

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: _____ Date: _____