Carolinas Physicians Network

ORG# _____

MRN# _____

## Patient Registration-Pediatric

| | Patient | Parent/Responsible Party- *if different* |
|---|---|---|
| | | Patient Relationship ☐ Parent ☐ Guardian |
| **Legal Last Name** | | |
| **Legal First Name, Middle** | | |
| **Nick Name** | | |
| **SSN** | | |
| **Date of Birth** | | |
| **Sex** | ☐ Male ☐ Female | |
| **Child Lives With** | ☐ Mother ☐ Father ☐ Grandparent ☐ Guardian | |

| | Mother / Guardian | Father / Guardian |
|---|---|---|
| **Date of Birth** | | |
| **Address** | | |
| **Apt/Bldg/Suite #** | | |
| **City, State, Zip** | | |
| **Home Phone** | | |
| **Work Phone** | | |
| **Mobile Phone** | | |
| **Email Address** | | |
| **Employer Name** | | |
| Address | | |
| City, State, Zip | | |

| | Emergency Contact *(Other than Parent/Guardian)* | Reason for visit _____ |
|---|---|---|
| Name | | |
| Address | | |
| Home Phone | | Who referred you? _____ |
| Work Phone | | Permission to leave voice mail @ primary phone number? |
| Mobile Phone | | ☐ Yes ☐ No |

| | 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

**Person responsible for payment of bill:** ☐ **Mother** ☐ **Father** ☐ **Guardian or Other** _____

**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: _____