

Carolina Kids Pediatric Associates, PLLC

Patient Information <i>Please list all children on this form to avoid having to complete a separate form for each child.</i>					
Patient #1: Last Name:		First Name:		MI:	Sex:
DOB:		Nickname:		MR# (office use only)	
Patient #2: Last Name:		First Name:		MI:	Sex:
DOB:		Nickname:		MR# (office use only)	
Patient #3: Last Name:		First Name:		MI:	Sex:
DOB:		Nickname:		MR# (office use only)	
Patient #4: Last Name:		First Name:		MI:	Sex:
DOB:		Nickname:		MR# (office use only)	
If more than 4 children, ask for a second form and list names here:					
Who do the children live with? Name:					
				Relationship:	
Children's Street Address:					
Apt/Unit #:					
City:		State:		Zip:	
Home Phone:					
Mother's Name:			Maiden Name:		
Mother's DOB:			SSN:		
Mother's Street Address:				Apt/Unit #:	
City:		State:		Zip:	
Mom's Daytime Phone:					
Father's Name:		DOB:		SSN	
Father's Street Address:				Apt/Unit #:	
City:		State:		Zip:	
Dad's Daytime Phone:					
Other Emergency Contact Name:			Relationship:		Phone:
Insurance Information <i>We file insurance as a courtesy.</i> <i>Remaining balance or non-covered charges are the responsibility of the patient or responsible parent/guardian.</i>					
You <u>must</u> present the patient's valid insurance card so we may keep a copy on file <u>before</u> we can file your claims.					
Medical Insurance Company:			Employer:		
Policy Holder Name:			DOB:		SSN:
Relationship to Patient:					
Responsible Parent/Guardian: <i>You CANNOT delegate another person to be the responsible party.</i> <i>Please complete this form in full today and request a blank form to take home if you plan to arrange for the responsible party to be changed.</i> <i>Copays and balance payments are expected at time of service, regardless of custodial agreements.</i>					
Responsible Parent / Patient / Guardian Name (print):					
DOB:		SSN:		Relationship to patient:	
Full Mailing Address:				Apt/Unit #:	
City:		State:		Zip:	
Daytime Phone:					
<i>I authorize Carolina Kids Pediatric Associates, PLLC to file insurance claims for services provided and for payments of services to be made to same. I authorize Carolina Kids Pediatric Associates, PLLC to release information in my child's record to any physician or institution as needed to provide medical care for my child. I may revoke this release of medical records in writing at any time. I understand that only written revocations will be accepted.</i>					
Responsible Parent / Patient / Guardian Signature:					Date: