Fayetteville Children's Clinic
P. O. Box 53127
Fayetteville, NC 28305

Chart #_____________
Primary Doctor: ______________
Updated by: _________________

Please note that insurance cannot be filed until ALL information is completed and a copy of your card is on file. Due to new guidelines set by the insurance companies, you may be required to present your insurance card at each visit. Please bring your most recent insurance card with you. Well child visits will be rescheduled for a more convenient time if the copay is not paid.

Patient information:

Name: First ______________________ Middle ____________ Last _____________________ Sex: M F Date of Birth: _____________

County: ______________________ Social Security #: ___________________ Home Phone: ____________

Street Address: __________________________________ City: ________________ State: __________ Zip Code: _______

Please circle if your child is covered by one of these policies:

NC Health Choice Medicaid BCBS Blue Advantage

If you circled Blue Advantage, is the child the only one on this policy? Yes No

Mother/Guarantor Information:

Name: _________________________________ Date of Birth: ___________________ Social Security# ________________

Relationship to child: Mother Step-Parent Grandparent Legal Guardian

Home address: ____ Mom's Maiden Name ___________________________

Work Phone: ______________ Cell Phone: _____________ Home Phone: ______________ Occupation: ________________

Internet Address: _____________________________________ Employer: ____________________________________

Do you have insurance with this company? Yes No

If yes, is the above named CHILD covered by this policy? Yes No If yes, a copy of the insurance card is REQUIRED.

Name of Insurance: ____ Effective Date: _______________________________

Father/Guarantor Information:

Name: __________________________________ Date of Birth: _________________ Social Security _______________________

Relationship to child: Father Step-Parent Grandparent Legal Guardian

Home address: ____

Work Phone: _______________ Cell Phone: _______________ Home Phone: ______________ Occupation: _______________________

Internet Address: ________________________________ Employer: ________________________________

Do you have insurance with this company? Yes No

If yes, is the above named CHILD covered by this policy? Yes No If yes, a copy of the insurance card is REQUIRED.

Name of Insurance: ____ Effective Date: ______________

If either parent/guardian is active duty military, please provide the following information:

Company Commander: ____ Unit: ______________________________________

Unit Phone # ____

I hereby authorize my insurance benefits to be paid directly to the above signed physician(s), realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers. This authorization shall be valid unless rescinded in writing by one of a later date.

Parent/legal guardian signature: ____