Patient Registration

FOR CLINIC USE

Chart # _____

Primary Doctor: _____

Updated by: _____

FAYETTEVILLE
CHILDREN'S CLINIC

P. O. BOX 53127 · FAYETTEVILLE, NC 28305

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.

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: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____ Occupation: _____

EMAIL ADDRESS: _____ Employer: _____

Do you have insurance with this employer? 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: _____

EMAIL ADDRESS: _____ Employer: _____

Do you have insurance with this employer? 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: _____

MILITARY INFORMATION

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

Company Commander: _____ Unit: _____

Unit Phone # _____

AUTHORIZED PERSONS

Please list persons other than yourself that are allowed to authorize treatment:

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

COMMUNICATION PERMISSION

May we leave detailed messages on an answering machine? Yes No

(such as appointment reminders, lab or test results, or referral appointments)

If yes, what is that number? _____

Whom may we thank for referring you! _____

_____ _____

Parent/Guardian Signature Date

_____ _____

Employee Signature Date