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| Carolina Kids Pediatric Associates, PLLC |
| **Patient Information**: *Please list all children on this form to avoid having to complete a separate form for each child.* |
| **Patient #1**: Name: Last First Middle |
| DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname |
| **Patient #2**: Name: Last First Middle |
| DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname |
| **Patient #3**: Name: Last First Middle |
| DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname |
| If more than 3 children, ask for a second form and list names here: |
| **Children’s Primary Address** Mom Dad Other (Name and relationship) |
| **First Parent Contact**: Relationship to patient Name: Last First MI |
| DOB Cell Phone Home Phone Maiden |
| Address Apt/Unit # |
| City State Zip Email (printed clearly) |
| **Second Parent Contact**: Relationship to patient Name: Last First MI |
| DOB Cell Phone Home Phone Maiden |
| Address Apt/Unit # |
| City State Zip Email (printed clearly) |
| **Alternate or Emergency Contact**: Name: Last First MI |
| DOB Relationship Phone Authorized to oversee pt care? Yes No |
| **Primary Insurance Info:** *Our office has contractual timely filing limits with insurance providers. Therefore, you may be responsible for claim balances if valid ins info is not provided within 85 days of service.* You **must** present the patient’s valid insurance policy information **before** we can file your claims.**To prevent filing errors DO NOT provide secondary insurance info unless it is Medicaid or Sisco.** |
| Primary Insurance Co Patient policy ID# Group# |
| **Policy Holder:** Name DOB Relationship to Patient |
| Primary Provider: (circle one) Tanaka Willey Emmet Hernandez Roschen |
| First Language Race Ethnicity (circle) Hispanic Non-Hispanic |
| How should we contact you for: **Well Check recalls** Call Text Email **Test Results**: Call Text Email  **Appointment Reminders** Call Text Email All emails and texts are generated by our EMR. |
| **Responsible Party Info:** ***You CANNOT delegate another person to be the responsible party.*** *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.* ***Copays and balance payments are expected at time of service.*** |
| Name: Last First Middle |
| DOB Relationship to patient Employer |
| Address Apt/Unit # |
| City State Zip Phone |
| **Responsible Party Name: Print Signature Date** |
| *I authorize Carolina Kids Pediatric Associates to file insurance claims for services provided and for payments of services to be made to same. I understand that I am responsible for any remaining balance or non-covered charges.*  **I have received a copy of Carolina Kids “Insurance and Billing” YES NO, if no please request one and check yes.**  **I have received a copy of Carolina Kids “Privacy Practices” YES NO, if no please request one and check yes.**  **Person Completing Form: Print Name Signature Date** |