WHITE OAK PEDIATRICS ASSOCIATES P.A.

4414 LAKE BOONE TRAIL, SUITE 103
RALEIGH, NC 27607
PHONE: (919) 787-0266

Date:_____ Chart #_____

Patient Information

Last Name:_____ First Name:_____ Middle Initial:_____ Sex:____

Date of Birth:_____ Age:_____years_____months Social Security Number:_____

Address:_____ Apt.#_____

City:_____ State:_____ Zip Code:_____

Home Number:_____ Work Number:_____ Cell Number:_____

If You are 18 and up please list a contact number:_____

Race: (check one) American Indian/Alaskan Native_____ Asian_____ Black/African American_____
Native Hawaiian_____ Other Pacific Islander_____ White_____ More than 1 Race_____ Declines to Respond_____

Ethnicity: (check one) Hispanic or Latino_____ Not Hispanic or Latino_____ Declines to Respond_____

Preferred Language:_____ Preferred Email Address:_____

Preferred Physician:_____

Preferred Notification Method: Postal Mail_____ Phone_____ (Home/Work/Cell) Circle One

Parents Information

Mom

Last Name:_____ First Name_____

Maiden Name:_____

DOB:_____ SS#_____

Mailing Address:_____

_____
City State Zip

Home Phone (_____) _____-_____

Cell Phone (_____) _____-_____

Work Phone (_____) _____-_____

Employer_____

Dad

Last Name:_____ First Name_____M.I.___

DOB:_____ SS#_____

Mailing Address:_____

_____
City State Zip

Home Phone (_____) _____-_____

Cell Phone (_____) _____-_____

Work Phone (_____) _____-_____

Employer_____

Emergency Contact (other than Parent) Name:_____ Phone:_____

Primary Insurance:_____ Policyholders Name:_____ DOB:_____

* Please list all persons authorized to schedule appointments, call for medical advise or bring your child/children to White Oak Pediatric Associates, P.A. for treatment.

NAME	RELATIONSHIP	PHONE NUMBER
1.		
2.		
3.		

Parent / Guardian Signature:_____ **Date:**_____

White Oak Pediatric Associates, PA

Financial Policy

Thank you for choosing White Oak Pediatric Associates, PA as your healthcare provider. We are dedicated to providing your child the best medical care and service possible. Part of that care involves working with you to insure you are aware of our financial policies and your payment responsibilities. The following is a statement of our Financial Policy.

Insurance

Your insurance policy is a contract between you and your insurance company. White Oak Pediatric Associates, PA is not a party to that contract. As a courtesy, we will file all claims to your insurance company. Please present your insurance card at each visit.

Co-pays

All copayments are to be paid at time of service. We accept **CASH, CHECKS, VISA, MASTERCARD, and DISCOVER AND AMERICAN EXPRESS.** A $25.00 fee for ***all*** returned checks will be charged to your account for **INSUFFICIENT FUNDS. (Refunds are issued after all claims have been paid and a credit balance is on the account)**

Self-Pay Patients

Self-pay patients are 100% responsible for all charges incurred and expected to make full payment at the time services are rendered. Some discounts may apply if balances due are paid in full at time of service. Please call and speak with one of our Billing Associates

Collections

Invoices not paid within 60 days begin our collection process. Accounts not paid within 60 days will be submitted to our Collection Agency. Please note a collection fee will be added to your account balance.

Transfer of Records

White Oak Pediatric Associates, PA may use an outside company for copying and transferring of records unless otherwise requested. This company is responsible for all copying fees and will bill you directly. White Oak Pediatric Associates, PA is not responsible for this billing nor receives compensation for this service.

I hereby acknowledge that I have read and agree to abide by White Oak Pediatric Associates, PA Financial Policy.

Signature of Guardian _____ **Date** _____