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 primarily live with(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)

Individuals Authorized to bring patient and oversee care:

1. Full Name Relationship Phone#

2. Full Name Relationship Phone#

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.* **To prevent filing errors, provide all active insurance information. By law Medicaid is payer of last resort.**

Primary Insurance: Patient policy ID# Group#

Policy Holder: Name DOB Relationship to Patient

Secondary Insurance: Patient policy ID# Group#

Policy Holder: Name DOB Relationship to Patient

Primary Provider: (circle one) Tanaka Willey Emmet Hernandez Roschen Micaela

First Language Race Ethnicity (circle) Hispanic Non-Hispanic

How should we contact you for: **Well Check recalls** ☐ Call ☐ Text ☐ Email

Appointment Reminders ☐ Call ☐ Text ☐ Email

Billing Statements ☐ Mail ☐ Patient Portal

Test Results: ☐ Call ☐ Text ☐ Email

All emails and texts are generated by our EMR.

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. You CANNOT delegate another person to be the responsible party. Copays and balance payments are expected at time of service. If a court agreement states that another parent is financially responsible for these medical costs, it is the accompanying parent's responsibility to pay at the time of the visit and collect reimbursement from the responsible parent.

Responsible Party Name: Print Name:

Signature: **Date:**