

# Patient Registration-Pediatric

ORG # \_\_\_\_\_

MRN # \_\_\_\_\_

<i>Patient</i>	<i>Parent/Responsible Party - if different</i> Patient Relationship <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Legal Last Name	
Legal First Name, Middle	
Nick Name	
SSN	
Date of Birth	
Sex/Race/Language <input type="checkbox"/> M <input type="checkbox"/> F Race _____ Language _____	<b>Primary Care Physician</b>
Child Lives With <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian	

<i>Mother / Guardian</i>	<i>Father / Guardian</i>
Date of Birth	
Address	
Apt/Bldg/Suite #	
City, State, Zip	
Home Phone	
Work Phone	
Mobile Phone	
Email Address	

Employer Name	
Address	
City, State, Zip	

<b>Emergency Contact (Other than Parent/Guardian)</b>	<b>Reason for visit</b> _____
Name	
Address	
Home Phone	Who referred you? _____
Work Phone	Permission to leave voice mail @ primary phone number?
Mobile Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Primary Insurance</b>	<b>Secondary Insurance</b>
Insurance Company	
Primary Policyholder Name	
Primary Policyholder DOB	
Primary Policyholder Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

**With whom, other than yourself, may we discuss your medical and billing information?**

1. \_\_\_\_\_ Phone \_\_\_\_\_ 2. \_\_\_\_\_ Phone \_\_\_\_\_  
 Name Name

Person responsible for payment of bill:  Mother  Father  Guardian or Other \_\_\_\_\_

**Authorization, Assignment of Benefits, and Referral Medical Release**

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to New Hanover Medical Group for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. Overpayments on any New Hanover Regional Medical Center Physicians Group/Carolinas Healthcare Associates accounts may be applied to your patient balance within the network. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Request for Treatment:**

The Group maintains personnel and facilities to assist the physicians in providing the medical care, and I authorize the Group personnel to perform the care ordered by the physicians. I understand that I have the right to be informed by the physicians of the nature and purpose of any proposed procedure and any available alternative methods or treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of the physician to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_