Date_____

Carolina Pediatric Group Patient Registration

Child's name_____ DOB_____ M / F SS#_____

Address_____ City_____ZIP_____
Primary phone number_____ Other phone contact_____
Child lives with:_____
Who is responsible for payment of medical services?_____
May we leave detailed messages on your voice mail? Yes No @ Phone number_____
Email address_____ May we send you information via email? Yes No

Mother/Guardian Information

Name_____
DOB_____ SS#_____
Primary phone_____ land/cell
Occupation and work phone_____

Father/Guardian Information

Name_____
DOB_____ SS# _____
Primary phone_____ land/cell
Occupation and phone_____

*If either parent/guardian is active duty military, please provide the following:
Unit_____ CO_____ Unit phone_____

Insurance Information

Primary_____
Policy ID#_____ Group_____
Claims address_____
Phone number_____
Policy holder's name_____
Policy holder's DOB _____
Policy holder's SS#_____

Secondary_____
Policy ID#_____ Group_____
Claims address:_____
Phone number_____
Policy holder's name_____
Policy holder's DOB_____
Policy holder's SS#_____

Does your child have any **allergies** to food, medications, insects, other? IF yes, give name and reaction. Include vaccine reactions. _____

Please list persons (other than those above) who are allowed to authorize medical treatment and immunizations in your absence. Attach additional paper if necessary.

_____ Phone#_____relationship_____

_____ Phone# _____ relationship_____

I authorize my insurance benefits to be paid directly to Carolina Pediatric Group's providers, realizing that I am responsible to pay non-covered services, and I also authorize the release of pertinent medical information to insurance carriers. This authorization shall be valid unless rescinded in writing.

Parent/Guardian signature_____ (date) _____

Whom may we thank for referring you?_____