

1540 Purdue Dr.
Suite 101
Fayetteville, N.C. 28303

Please note that Insurance cannot be filed until ALL information is completed and a copy of your card is on file. Periodically, you will be asked for your insurance card. This is due to new requirements by insurance companies. So always bring your most recent card with you. Well child visits will be rescheduled for a more convenient time if the copay is not paid.

Child's Name: _____ Sex: M F Birthday: _____

Child's Nickname: _____ Social Security #: _____ Home Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Please circle if your child is the covered by one of these policies.

N.C. Health Choice Medicaid BCBS Blue Advantage

If you circled Blue Advantage, is the Child the only one on this policy? Yes No

Parent/Guardian Information:

Name: _____ Birthday: _____ Social Security #: _____

Relationship to the child: Mother Father Step-Parent Grandparent Legal Guardian

Work Phone #: _____ Cell Phone#: _____ Occupation: _____

Employer: _____ Do you have insurance with this company? Yes No

Is the above named **CHILD** covered by this policy? Yes No If yes please provide us with a copy of the card.

Name of Insurance: _____ Effective Date: _____

Parent/Guardian Information:

Name: _____ Birthday: _____ Social Security #: _____

Relationship to the child: Mother Father Step-Parent Grandparent Legal Guardian

Work Phone #: _____ Cell Phone#: _____ Occupation: _____

Employer: _____ Do you have insurance with this company? Yes No

Is the above named **CHILD** covered by this policy? Yes No If yes please provide us with a copy of the card.

Name of Insurance: _____ Effective Date: _____

If the either parent/guardian is active duty military, please provide the following information.

Company Commander: _____ Unit: _____

Unit Phone Number: _____

Is your child allergic to any Medications or Food? Yes No

If yes, please list what they are allergic to and their reaction.

Please list persons other than yourself that are allowed to authorize treatment.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

May we leave detailed messages on an answering machine? Yes No

(Such as appointment reminders, lab or test results, or referral appointments)

If yes what is that number: _____

Parent/Guardian Signature

Date

Employee Signature

Date

Who may we thank for referring you: _____