

## Welcome Today to Raleigh Children & Adolescents Medicine

- We ask that you **make corrections and additions** below and sign (**\***) to guarantee **complete contact information** for your family and **effective communication** with your health insurance company.
- **Thank you for your patience.** We try to keep our forms as simple as possible. The specifics below are necessary to achieve the accuracy required for filing insurance claims under a variety of circumstances.
- **Please present your insurance card** (we are required to document it *with every visit* to our office).

Your Child's Full Name	Family E-Mail Address (for appt. reminders)	County of Residence
Primary Home Mailing Address	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone
	Date of Birth	Work Phone for:

- **Parent's information (complete only the portion different from or not included above):**

M O T H E R			F A T H E R		
Mother's name			Father's name		
Mother's Social Security Number	Mother's Date of Birth		Father's Social Security Number	Father's Date of Birth	
Mother's Address		Mother's Employer	Father's Address		Father's Employer
Mother's Home Phone	Mother's Mobile Phone	Mother's Work Phone	Father's Home Phone	Father's Mobile Phone	Father's Work Phone

- **Insurance information:**

Guarantor's Name		Guarantor's Address (if different from above)			
Guarantor's Social Security Number	Guarantor's Employer				
PRIMARY Health Insurance					
Name of Primary Insurance Company				Effective Date	
Policy Holder's Name			Relationship to Patient	Policy Holder's Date of Birth	
ID Number	Group Number		Copay	Deductible	
<b>**Please list other children covered under this PRIMARY health insurance policy on the back of this page**</b>					
SECONDARY Health Insurance (if any)					
Name of Secondary Insurance Company				Effective Date	
Policy Holder's Name			Relationship to Patient	Policy Holder's Date of Birth	
ID Number	Group Number		Copay	Deductible	
<b>**Please list other children covered under this SECONDARY health insurance policy on the back of this page**</b>					

I verify that I have been offered a copy of this office's Notice of Privacy Practices (HIPAA policy).

**\***

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)