

RALEIGH CHILDREN AND ADOLESCENTS MEDICINE

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PLEASE PRINT FULL BIRTH NAMES

Patient Name: _____ Sex M or F
(First) (Middle) (Last)

Date of Birth: _____ Social Security #: _____

Patient Name: _____ Sex M or F
(First) (Middle) (Last)

Date of Birth: _____ Social Security #: _____

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

Home Phone #: _____ Alternate or Cell Phone #: _____

Father's Name _____ Date of Birth: _____
(First) (Middle) (Last)

Address(if different) _____
(Street) (City) (State) (Zip Code)

Social Security #: _____ Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Mother's Name _____ Date of Birth: _____
(First) (Middle) (Last)

Address(if different) _____
(Street) (City) (State) (Zip Code)

Social Security #: _____ Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Name of Friend or Relative who can be reached in case of an emergency: Name: _____

Address: _____ Phone: _____

How did you hear about our practice? _____

PLEASE TURN OVER AND COMPLETE BACK

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____ Effective Date: _____

Policy Holder's Name: _____ Date of Birth: _____
(Parent that carries the insurance)

Employer: _____ Relationship to patient: _____

ID#: _____ Group#: _____ Copay: _____ Deductible: _____
(Member/subscriber #)

Other Children that are covered under this policy: _____

SECONDARY INSURANCE COMPANY: _____ Effective Date: _____

Policy Holder's Name: _____ Date of Birth: _____
(Parent that carries the insurance)

Employer: _____ Relationship to patient: _____

ID#: _____ Group#: _____ Copay: _____ Deductible: _____
(Member/subscriber #)

Other Children that are covered under this policy: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THE POLICY IN OUR OFFICE IS: The parent who requests treatment for the child is responsible for services rendered. Payment is required at each office visit.

(Signature of Parent Requesting Care)

(Date)

I AUTHORIZE RALEIGH CHILDREN AND ADOLESCENT MEDICINE, P.C.:

***to file insurance claims for all services provided to my dependent(s) and I authorize payment for those services to be made directly to the provider.**

***to release information about my dependent(s) to any referring physician or other provider or to any institution as necessary to provide treatment or diagnosis for my dependent(s).**

***and the physician or other provider(s) to release information about me as necessary to process claims for payment for services provided to me, including to health and liability insurance companies; agencies processing Medicaid, or Workers' compensation claims; medical benefit plans, case managers, or reviewers; or third parties responsible for paying claims for services provided to me.**

I understand that I am financially responsible for all services not covered by my insurance, including, but not limited to co-payments, deductibles, and non-coverage of services.

(Signature of Parent)

(Date)