Fayetteville Children's Clinic
P. O. Box 53127
Fayetteville, NC 28305

Chart #_____
Primary Doctor: _____
Updated by: _____

Please note that insurance cannot be filed until ALL information is completed and a copy of your card is on file. Due to new guidelines set by the insurance companies, you may be required to present your insurance card at each visit. Please bring your most recent insurance card with you. Well child visits will be rescheduled for a more convenient time if the copay is not paid.

Patient information:

Name: First _____Middle_____Last_____Sex: M F Date of Birth: _____

County: _____ Social Security #:_____ Home Phone: _____

Street Address: _____ City: _____State:_____ Zip Code: _____

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

NC Health Choice Medicaid BCBS Blue Advantage

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

Mother/Guarantor Information:

Name: _____ Date of Birth: _____ Social Security# _____

Relationship to child: Mother Step-Parent Grandparent Legal Guardian

Home address: _____

Work Phone: _____Cell Phone: _____ Home Phone: _____Occupation: _____

EMAIL ADDRESS:_____Employer:_____

Do you have insurance with this employer? Yes No

If yes, is the above named CHILD covered by this policy? Yes No If yes, a copy of the insurance card is REQUIRED.

Name of Insurance: _____Effective Date:_____

Father/Guarantor Information:

Name: _____ Date of Birth: _____ Social Security _____

Relationship to child: Father Step-Parent Grandparent Legal Guardian

Home address: _____

Work Phone: _____Cell Phone: _____ Home Phone: _____Occupation: _____

EMAIL ADDRESS: _____ Employer:_____

Do you have insurance with this employer? Yes No

If yes, is the above named CHILD covered by this policy? Yes No If yes, a copy of the insurance card is REQUIRED.

Name of Insurance: _____Effective Date: _____

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

Company Commander: _____Unit:_____

Unit Phone # _____

If you do not have a home phone (landline) and wish to be contacted on your cell/mobile phone, please read and sign the paragraph below.

I have given a cell/mobile phone number as my main contact number. I understand that I may be subject to receiving telephone calls from a live operator or an automated dialer using a pre-recorded, artificial voice message. I give my consent to receive such calls.

_____

Parent/Guardian

_____

Date

_____

Witness

Is your child allergic to any Food or Medications? 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

Whom may we thank for referring you! _____