

CATAWBA PEDIATRIC ASSOCIATES, P. A.

ACCOUNT # \_\_\_\_\_

PATIENT DATA 2007

DATE: \_\_\_\_\_

Child's Name

Nombre Apellido: \_\_\_\_\_ (Last Name) (First Name) (Middle Name) Date of Birth / Fecha de Nacimiento: \_\_\_\_\_

SS#/Seguro: \_\_\_\_\_ Nickname: \_\_\_\_\_ Sex: Male Female Race: \_\_\_\_\_

Address/Direccion: \_\_\_\_\_ (No. Street) (Apt #) (P. O. Box) (City) (State, ZIP)

Home Phone/Telefono: \_\_\_\_\_

Father's Full Name \_\_\_\_\_ Home Phone/Telefono: \_\_\_\_\_

SS#/Seguro: \_\_\_\_\_ Date of Bith/ Fecha de Nacimiento: \_\_\_\_\_

Address/Direccion (if different): \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone/ Telefono del Trabajo: \_\_\_\_\_ Are calls allowed? \_\_\_\_\_

Mother's Full Name \_\_\_\_\_ Home Phone/Telefono: \_\_\_\_\_

SS#/Seguro: \_\_\_\_\_ Date of Bith/ Fecha de Nacimiento: \_\_\_\_\_

Address/Direccion (if different): \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone/ Telefono del Trabajo: \_\_\_\_\_ Are calls allowed? \_\_\_\_\_

PERSONS TO CALL IF UNABLE TO REACH YOU

Name/Nombre: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone/ Telefono: \_\_\_\_\_

Address/ Direccion: \_\_\_\_\_

Name/Nombre: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone/ Telefono: \_\_\_\_\_

Address/ Direccion: \_\_\_\_\_

NAME OF PARENT OR GUARDIAN RESPONSIBLE FOR MEDICAL EXPENSES

Name/ Nombre: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

SS#/Seguro: \_\_\_\_\_ Date of Bith/ Fecha de Nacimiento: \_\_\_\_\_

Address/Direccion (if different): \_\_\_\_\_

Phone/ Telefono: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone/ Telefono del Trabajo: \_\_\_\_\_

I give permission for Catawba Pediatric Associates, P. A. or persons designated by them to interview, examine, and perform necessary laboratory/radiological procedures and to provide appropriate treatment to the above named minor. Permission for evaluation and treatment granted whether child presented by parent, family member, unrelated party, or accompanied.

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize Catawba Pediatric Associates, P.A. to furnish information concerning my child \_\_\_\_\_ to my insurance carriers, to other medical personnel to whom physicians of Catawba Pediatrics have referred my child for treatment, and to the admitting hospital should my child be admitted.

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

All professional services are charged to the patient. Payment for office charges is due at the time of service. Patients covered under a contracted insurance plan are responsible for any co-payment, deductible, or coinsurance at the time of service. Patients covered under non-contracted insurance plans are responsible for filing all office charges with their insurance carrier. The patient is responsible for all fees, regardless of insurance coverage. Divorce has no bearing on the responsibility for medical care as it affects third parties. Catawba Pediatrics does not get involvd in payment disputes between parents.

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Other Family Members Who are Patients at Catawba Pediatrics:

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date and Changes in above information (i.e. new address, phone #) or explanation (i.e. "Parent separation, " "child living with grandmother, " etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_