



CPAM CHART # _____

WE IMMUNIZE
FOLLOWING THE 2008 CDC CHILDHOOD AND
ADOLESCENT IMMUNIZATION SCHEDULE

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MOORESVILLE, NORTH CAROLINA 28117

PATIENT REGISTRATION & ACKNOWLEDGEMENT OF INSURANCE/BILLING

PATIENT	Last Name, First Name, Middle Name of Patient <i>(Please Print or Type)</i>		Patient Name Called
	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
	Street Address or Post Office Box		Patient Date of Birth
	City, State, Zip Code		Patient Social Security #
	Patient Lives With: <i>(Please Check)</i>	Home Phone # <i>(OK to Leave Message?)</i>	Cell Phone or Alternate #
<input type="checkbox"/> BOTH PARENTS <input type="checkbox"/> MOM <input type="checkbox"/> GUARDIAN <input type="checkbox"/> GRANDPARENT(S) <input type="checkbox"/> DAD <input type="checkbox"/> OTHER		<input type="checkbox"/> YES <input type="checkbox"/> NO	

BILLING CONTACTS	Last Name, First Name, Middle Initial of Person Responsible for Payment of Services		Home/Cell Phone # <i>(If Different)</i>
	<input type="checkbox"/> DAD <input type="checkbox"/> MOM <input type="checkbox"/> OTHER		
	Street Address or Post Office Box <i>(If Different)</i>		Place of Employment
	City, State, Zip Code		Work Phone #
	First, Middle Initial, Last Name of Other Parent/Guardian		Other Parent's Place of Employment
<input type="checkbox"/> DAD <input type="checkbox"/> MOM <input type="checkbox"/> OTHER			

INSURANCE	Last Name, First Name, Middle Initial of Insurance Policy Holder - <i>(Subscriber)</i>		Policy Holder's Social Security #
	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
	Primary Insurance Company <i>(Copy of Current Insurance Card Required)</i>	Co-Pay	Policy Holder's Date of Birth
		\$	
Policy ID #	Group ID #	Effective Date of Current Policy	

I hereby authorize and/or understand (a) payment of insurance benefits otherwise due to me to be made directly to the Center for Pediatric and Adolescent Medicine, (b) the release of information to insurance companies as needed to file for payment for services incurred, (c) the Center for Pediatric and Adolescent Medicine to obtain records from other sources as may be necessary in the diagnosis or treatment of the stated patient, and (d) I am financially responsible for payment to the Center for Pediatric and Adolescent Medicine for charges related to services provided to or incurred by me or my dependents including but not limited to co-pay and co-insurance amounts, deductible amounts, charges for treatments not covered by insurance, and/or insurance filed with inaccurate/terminated coverage information, (e) the Center for Pediatric and Adolescent Medicine will bill me directly any balances for office visits, services and/or procedures should the insurance company I provided to them not respond to the filing of the medical claim within 90 days of the date of service, and (f) to the best of my knowledge, the information presented by me is accurate and correct.

REQUIRED SIGNATURE

Signature of Patient or Patient Representative _____ Date _____

Print Name of Patient Representative and Relationship to Patient _____

E-Mail Address _____ (E-mail Correspondence Form) Yes No

How did you find out about our practice? Friend Professional Referral Web Site Advertisement Other: _____
(Please State)

2008

***** PLEASE NOTE ***
TO BE REGISTERED AS A PATIENT,
ALL INFORMATION ABOVE MUST
BE FILLED OUT COMPLETELY**

Primary MD Request: Tilt Little Thomas