EASTERN CAROLINA PEDIATRIC ASSOCIATES

PATIENT INFORMATION

CHART# (P-DATA):

Last Name	First Name	Middle Name
Preferred Name	Ethnicity: ❑ Non-Hispanic ❑ Latino/Hispanic	

Mailing Address	City	State	Zip
Street Address	City	State	Zip

Home Phone #	Social Sec. #	Date of Birth	Sex

Race

❑ White ❑ Black/African American ❑ Asian

❑ More than 1 race ❑ Native Hawaiian/Pac. Isl.

❑ American Indian/Alaskan Native

Preferred Language	Preferred Provider
Preferred Email	

PARENT INFORMATION

Father's Last Name	First Name	M.I.	Home Phone #
			Cell Phone #
Mailing Address		Birth Date	Soc. Sec. #
Employer Name	Address		Work Phone #

Mother's Last Name	First Name	M.I.	Home Phone #
			Cell Phone #
Mailing Address		Birth Date	Soc. Sec. #
Employer Name	Address		Work Phone #

INSURANCE INFORMATION

Primary Insurance	Address		
Policyholder Name	Date of Birth	Policy ID#	Group #

Secondary Insurance	Address		
Policyholder Name	Date of Birth	Policy ID#	Group #

IN CASE OF EMERGENCY: (PLEASE NOTIFY) (OTHER THAN PARENT) PHONE #

I HEREBY GRANT CONSENT FOR MEDICAL TREATMENT AND AUTHORIZE THE RELEASE OF ANY MEDICAL/OTHER INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. THIS OFFICE IS NOT RESPONSIBLE FOR ANY DISSEMINATION OR DISCLOSURE OF YOUR CONFIDENTIAL MEDICAL INFORMATION ONCE WE PROVIDE SUCH INFORMATION, AT YOUR REQUEST, TO YOUR HEALTH INSURER OR EMPLOYER. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THIS PRACTICE FOR SERVICES RENDERED. I ALSO UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE TO PAY FOR ANY SERVICES RENDERED.

PARENT/LEGAL GUARDIAN SIGNATURE DATE

Name(s) of person(s) authorized by me to seek medical treatment for my child(ren) in my absence.

OTHER CHILDREN IN THIS PRACTICE

Full Name DOB	Full Name DOB
1.	1.
2.	2.
3.	3.

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Eastern Carolina Pediatric Associates is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays Other _____
☐ Provide name & phone number _____	☐ Financial ☐ Medical as follows: _____
☐ Provide name & phone number _____	☐ Financial ☐ Medical as follows: _____
☐ Provide name & phone number _____	☐ Financial ☐ Medical as follows _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

_____