Dr. W. Stanley Rule, M.D.

3604 Medical Park Ct., Morehead City, NC 28557
Phone: (252) 240-5437 Fax: (252) 240-3084

CHILD BEING SEEN TODAY

Child's Full Name: _____
first middle last suffix

Child's mailing address: _____
street city/state/zip

Date of Birth: _____ Social Security No.: _____ Gender: Male/ Female

Ethnicity: Non-Hispanic/ Hispanic/ Unknown **Race**: Am. Indian or Eskimo/ Asian/ Black/ Hawaiian or Pac Isl/ White **Primary Language**: _____

Lives with: mother father both natural parents other:_____

Parent/Guardian Information:

Father/Guardian Name: _____

Social Sec. No.:_____

Date of Birth:_____

Mailing Address:_____

City:_____ State: _____ Zip: _____

Phone (H):_____ (W):_____

Mobile:_____ Other:_____

E-Mail:_____

Employer/Occupation:_____

Mother/Guardian Name: _____

Social Sec. No.:_____

Date of Birth:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Phone (H):_____ (W):_____

Mobile:_____ Other:_____

E-Mail:_____

Employer/Occupation:_____

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon_____

Please list any legal step parents involved in this child's care

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

How do you prefer to be contacted? (Please circle one) HOME PHONE / MOBILE PHONE

Please complete this section if there is a court ordered custody agreement. We will need a copy of this documentation.

If parents are separated, divorced or not married, who has custody? FATHER / MOTHER / JOINT / OTHER _____

Are there any **LEGAL** restrictions for either parent that would keep them from consenting to medical treatment for child? YES or NO

(If yes, please explain)_____

Insurance Information:

Primary Insurance Co.:_____ Secondary Insurance Co.:_____

Please List A Pharmacy and Location: _____

Please List ALL Other Children

Name:_____ DOB:_____ Our patient Circle Yes No

Name:_____ DOB:_____ Our patient Circle Yes No

Name:_____ DOB:_____ Our patient Circle Yes No

Emergency Contacts (LOCAL and not a parent)

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Please provide us with a list of individuals or individual that you give permission to release information to regarding your child other than the parents or guardians. Due to HIPAA laws in place nothing will be disclosed unless this person or persons are listed below. Your child cannot be treated by our practice if brought in by anyone other than the parent, legal guardian, or persons listed below. By listing these names, you are giving the individual authority to make medical decisions in your absence and access to medical records regarding your child.

(1) _____Phone Number_____
Name relationship

(2) _____Phone Number_____
Name relationship

Our office values your time. Appointment times are yours and yours alone. If you do not keep this time, you deprive someone else of this opportunity to seek care. Our policy regarding missed appointments is as follows:

2 missed appointments within a 12-month period; you will be given a "warning letter" that will go in your file. A 3rd missed appointment within that 12-month period; you will receive a letter of "exit" from our practice. We hope these will not be necessary and that you value our time as well as others.

A "courtesy" phone call is usually given in advance of your child's appointments. It is ***not*** our responsibility to "remind" you of your appointments, it is a "courtesy." Emergencies come up in our office and these phone calls are not mandatory, so please let us know within 24 hours of any changes you may have for your appointments.

As a courtesy to you, our office also will file your insurance for you. We will then need a copy of your insurance card with all updated information. *We need this at the time of your appointment or you will be responsible to pay in full and file your own insurance.* We participate with BCBS, Tricare Standard and Prime, Aetna, Medcost, Cigna, NC Health Choice, Medicaid, United Healthcare, and all other insurance plans will be expected to pay at the time of service.

MEDICAID patients must present current card at **EVERY** visit.

I hereby authorize W. Stanley Rule, M.D. to furnish information to my insurance carrier concerning my child's illness and treatment, and hereby assign payments to be made to Dr. Rule. I understand that I am ultimately responsible for my bill, regardless of payment by my insurance carrier. I authorize use of a photocopy of this document in lieu of the original by my signature below.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE.

SIGNATURE:_____ Relationship to patient:_____

Print Name:_____Date:_____