KIDS RULE PEDIATRICS, PA
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. Please kindly give 24 hour notice if you cannot make the appointment, or you need to reschedule.

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.

**Please note that we are part of the NC Health Information Exchange because of the many benefits sharing health information electronically. You may choose not to participate ("opt-out"). Your choice to opt-out will not affect your ability to access medical care. You can opt out by calling
855-926-1042 or by filling out the opt-out form available at the front desk or online at https://hiea.nc.gov. **

I hereby authorize Kids Rule Pediatrics to furnish information to my insurance carrier concerning my child's illness and treatment, and hereby assign payments to be made to Kids Rule Pediatrics. 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:________________