

Chapel Hill Children's Clinic, P.A.
301 Kildaire Rd, Suite 200
Chapel Hill, NC 27516
(919) 967-0771 Fax (919) 967-9207

NEW PATIENT
INTAKE FORM

PLEASE COMPLETE ONE FORM FOR EACH CHILD PRIOR TO HIS/HER INITIAL VISIT
PLEASE USE BLACK INK

DATE: _____ FOR OFFICE USE:
FULL LEGAL NAME: _____ PATIENT NUMBER
PREFERRED NAME: _____
DATE OF BIRTH: _____ GENDER: _____
HOME PHONE: () _____ EMAIL ADDRESS: _____
STREET ADDRESS: _____ APT NO. _____
CITY: _____ STATE: _____ ZIP: _____
HOW DID YOU HEAR ABOUT US? _____

PARENTS/GUARDIANS:

NAME:	HOME PHONE:	CELL PHONE:	WORK PHONE:	SSN:
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	()	()	()	
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INSURANCE INFORMATION: **(PLEASE COMPLETE FULLY EVEN IF COPY OF CARD TAKEN)**

NAME OF CARRIER: _____

CLAIMS ADDRESS: _____

POLICY/SUBSCRIBER NUMBER: _____

GROUP NAME/NUMBER: _____

POLICYHOLDERS NAME: _____ SSN: _____

EMPLOYER'S NAME: _____

PAYMENT POLICY: (PLEASE READ AND SIGN THE STATEMENT BELOW)

PAYMENT FOR CLINIC SERVICES IS EXPECTED AT THE TIME THEY ARE RENDERED. CASH, CHECK AND CREDIT CARDS (MC, VISA AND DISCOVER) ARE ACCEPTED. INDIVIDUAL POLICYHOLDERS SHOULD SEEK COMPENSATION FOR SERVICES THROUGH THEIR INSURANCE COMPANIES. THE CLINIC WILL ASSIST IN PROVIDING USEFUL INFORMATION IN THIS REGARD BUT CANNOT SERVE AS THE PATIENT'S AGENT.

THERE ARE, OF COURSE, EXCEPTIONS TO THE ABOVE POLICY. ARRANGEMENTS FOR ALTERNATIVE PAYMENT PLANS MUST BE MADE IN ADVANCE OF SERVICES RENDERED. PLEASE DISCUSS THESE WITH THE CLINIC REPRESENTATIVE.

SIGNATURE: _____

FINANCIALLY RESPONSIBLE PARTIES:

NAME:	RELATIONSHIP TO PATIENT:	SSN:	DAYTIME PHONE NUMBER:

EMERGENCY CONTACT INFORMATION: (NAME, ADDRESS AND PHONE NUMBER OF NEAREST RELATIVE OR FRIEND OTHER THAN PARENT)

NAME: _____

ADDRESS: _____

PHONE: (_____) _____ RELATIONSHIP: _____

SIGNATURE OF PERSON COMPLETING FORM: _____