Chart #:
Staff Initials:

Burlington Pediatrics
Mebane Pediatrics
By your side for a healthy future

Patient Information *(self if over 18)*:

Name _____
Last Name *First Name* *MI* *Suffix*

Date of Birth _____ Gender: ☐ FEMALE ☐ MALE ☐ PREFER NOT TO SPECIFIY

Address _____ City _____ State _____ Zip Code _____

County of Residence _____ Phone _____ Email _____

PARENTAL INFORMATION

LEGAL GUARDIAN (self if over 18)
☐ check if SAME address ☐ Self [IF applicable]
Name _____
Relationship to Patient: ☐ Mother ☐ Father
☐ Other (legal doc required): _____
DOB _____ SSN# _____
Mailing Address _____
City _____State_____ Zip Code_____
Cell Phone _____
Alternate Phone _____
Preferred Language _____
Email _____

LEGAL GUARDIAN
☐ check if SAME address
Name _____
Relationship to Patient: ☐ Mother ☐ Father
☐ Other (legal doc required): _____
DOB _____ SSN# _____
Mailing Address _____
City_____ State_____ Zip Code_____
Cell Phone _____
Alternate Phone _____
Preferred Language _____
Email _____

Who does the child reside with? ☐ Father ☐ Mother ☐ Both ☐ Other_____
Who has legal custody of the child? ☐ Father ☐ Mother ☐ Both ☐ Other (legal doc required) _____

Please provide any applicable legal documents.

INSURANCE INFORMATION **PLEASE NOTE: YOU MAY BE ASKED TO PRESENT YOUR INSURANCE CARD AT EVERY VISIT**

PRIMARY INSURANCE
Insurance Company _____
Member/Subscriber# _____
Group # _____
Subscriber's Name _____
Subscriber's DOB _____

SECONDARY INSURANCE
Insurance Company _____
Member/Subscriber # _____
Group # _____
Subscriber's Name _____
Subscriber's DOB _____

EMERGENCY CONTACT: *other than parent or self (if over 18)*

Name _____ Relationship _____Phone _____

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

I authorize the release of protected health information to any consultant for the purpose of continuing care. I authorize the release of information acquired in the course of my child's examination for the purpose of filing insurance claims. I assign insurance payment directly to Burlington Pediatrics. I understand that I am ultimately responsible for payment of charges whether or not they are covered by insurance. This authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be valid as the original.

Date _____ Signature _____
Relationship to Patient _____