

Welcome to Our Practice

PATIENT INFORMATION

Today's Date ____/____/____

Child's Legal Name _____

SS# _____-_____-_____

Nickname (if any) _____

Age _____ Date of Birth ____/____/____ Sex _____

Names of your other children who are patients here:

Parent/Legal Guardian Responsible for Account Information

Mother/Legal Guardian's Name _____

Date of Birth ____/____/____ SS# _____-_____-_____

Home Address _____

City State Zip

Home Phone (____) _____-_____

Cell Phone (____) _____-_____

Place of Employment _____

Work Phone (____) _____-_____ Ext _____

Father/Legal Guardian's Name _____

Date of Birth ____/____/____ SS# _____-_____-_____

Home Address _____

City State Zip

Home Phone (____) _____-_____

Cell Phone (____) _____-_____

Place of Employment _____

Work Phone (____) _____-_____ Ext _____

Emergency Contact's Name (other than the Parent's) _____

Home Phone (____) _____-_____

Cell Phone (____) _____-_____

If parents are divorced who has legal custody of child?

How did you hear about our practice?



2315 W. Arbors Dr, #115 ● Charlotte, NC 28262
Phone: (704) 717-2826 ☎ Fax: (704) 971-5014

Who, if anyone other than the responsible party, has permission to be involved in your child's medical treatment including bringing them in for visits?

Name Relationship

Name Relationship

Insurance Assignment and Releases

I, the undersigned hereby assign, transfer and set over to Starks Pediatrics all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from the medical and/or surgical services performed for me by Starks Pediatrics and I direct my insurance company to pay any and all such entitlements directly to Starks Pediatrics.

Parent or Legal Guardian Responsible for Account

I authorize Starks Pediatrics to render medical care to my child. I understand that all co-pays and deductibles are to be paid at the time of service. In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I understand that any and all of my child's future appointments will be canceled and I cannot schedule any further appointments until the account is resolved, and I agree to pay any and all costs of collection including attorney's fees. In the event that my child is referred to a specialist or hospitalized, I authorize the release of any medical information necessary to process an insurance claim. I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for charges not covered by the policy including any administrative fees due to late cancellation/rescheduling of an appointment, missing an appointment altogether, and any fees for medical records. I will assist in the collection of my insurance benefit should there be any delay in payment.

Parent or Legal Guardian Responsible for Account

I have received the attached sheet "Starks Pediatrics Financial Policy"

Parent or Legal Guardian Responsible for Account

I have received the attached "Notice of Privacy Policies", detailing how my information may be used and disclosed as permitted under federal and state law. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions.

Parent or Legal Guardian Responsible for Account