CAROLINAEAST
PEDIATRICS

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OFFICIAL USE ONLY: TODAY'S DATE ____ / ____ / _____ MRN: _____

CarolinaEast Pediatrics complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PATIENT REGISTRATION, BENEFICIARY AGREEMENT AND CONSENT

FIRST NAME _____ **MI** ____ **LAST** _____ **BIRTHDATE** ____ / ____ / _____

SSN: ____ - ____ - _____ **GENDER** ☐ F ☐ M **MARITAL STATUS** ☐ Single ☐ Married ☐ Widowed ☐ Legally separated ☐ Divorced

ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Filipino ☐ Unknown ☐ Decline to answer

PREFERRED LANGUAGE *(only one please)*: _____

RACE ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown ☐ Asian ☐ White or Caucasian ☐ Decline to answer ☐ Black or African American ☐ Other Race

PRIMARY CARE PROVIDER _____

MAILING ADDRESS
_____
Street and/or PO
_____
City, State, Zip Code

PHYSICAL ADDRESS if different from mailing address
_____
Street and/or PO
_____
City, State, Zip Code

TELEPHONE
Home: (____) ____ - _____
Mobile: (____) ____ - _____
Work: (____) ____ - _____

EMAIL _____

EMPLOYMENT ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

EMPLOYER _____ Phone: (____) ____ - _____
Address: _____

SPOUSE/PARENT/GUARDIAN
Name: _____ DOB: ____ / ____ / _____
Phone: (____) ____ - _____ Employer: _____

EMERGENCY CONTACT
Name: _____ DOB: ____ / ____ / _____
Phone: (____) ____ - _____ Relationship: _____

INSURANCE INFORMATION

PRIMARY _____ **SECONDARY** _____
Holder's Name: _____ Holder's Name: _____
DOB: ____ / ____ / _____ SSN: ____ - ____ - _____ DOB: ____ / ____ / _____ SSN: ____ - ____ - _____

Do you have a third (3rd) insurance? ☐ Yes ☐ No

BENEFICIARY AGREEMENT

By signing this form, I acknowledge the accuracy of the information listed on this form, and I also accept/agree to the following:
CONSENT FOR EXAMINATION I hereby voluntarily present myself to CarolinaEast Physicians for examination, treatment, and medical or nuclear procedures and do hereby consent to medical services as may be deemed necessary by my physician at CarolinaEast. **RELEASE OF INFORMATION** I authorize CarolinaEast Physicians to release any information needed to determine medical necessity and payments of benefits to my insurance carrier-and-release requested medical information that relates to my treatment here to my referring Physicians or _____. **FOR ALL PATIENTS NOT COVERED BY MEDICARE OR OTHER GOVERNMENTAL PROGRAM** I assign and authorize CarolinaEast Physicians to submit a claim to my insurance carrier(s) for all covered services rendered by their physicians and DIRECT MY INSURANCE CARRIER(S) OR THEIR AGENT(S) TO PAY CAROLINAEAST PHYSICIANS. I understand that I am financially responsible for any and all charges not met by the proceeds of this assignment and for all charges or should said proceeds not be paid in a reasonable time after charges are filed with the carrier, or should the carrier deny or reduce payment below CarolinaEast Physicians' charge. I understand that I will be legally responsible for all collection costs ($25.00) involved with the collection of this account including all court costs, reasonable attorney fees, and all other expenses incurred with the collection if I default on this agreement. I am hereby notified by CarolinaEast Physicians that insurance carriers will deny payment for routine exams or tests where there are no symptoms or positive findings. They can also determine that certain exams and tests are not 'medically necessary'. **FOR ALL PATIENTS COVERED BY MEDICARE, MEDICAID, MEDIGAP, TRICARE, OR OTHER GOVERNMENT PROGRAMS** I request payments or authorized benefits be made on my behalf by Medicare, Medicaid, Medigap, Tricare, or other governmental agency is paid directly to CarolinaEast Physicians for medical services furnished to me by their physicians. I understand that I am responsible for any deductible and coinsurance of allowable charges not otherwise covered. I am hereby notified by CarolinaEast Physicians that the above carriers or agencies may deny payment for routine exams and procedures that are not medically necessary, and that I agree to be personally responsible in such cases.

Signature of Patient -or- Representative

Date of signature / /

Representative's printed name

Representative's birth date / /

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 252-636-1919.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 252-636-1919.