Greenville Pediatric Services, Inc.

300 Bethesda Drive • Greenville NC 27834 • Tel: 252-752-7141 • Fax: 252-752-0223

Patient Information

Patient Name:_____ Sex: M ☐ F ☐ DOB: ____ / ____ / ____

Race:_____ Language:_____ Ethnicity: Hispanic / Latino ☐ Not-Hispanic / Latino ☐

Provider Preference (circle one): Prevatte Coker Sutton Ogle Thielen Manning Seemann Rivenbark Roebuck

Preferred Method of Contact: Phone ☐ Postal Mail ☐ Patient Portal ☐

Parent Information

Mother/Guardian:_____ DOB: ____ / ____ / ____ SS#:_____

Address:_____ Home Phone:_____

City/State/Zip:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

Preferred Email Address:_____

Father/Guardian:_____ DOB: ____ / ____ / ____ SS#:_____

Address:_____ Home Phone:_____

City/State/Zip:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

Preferred Email Address:_____

Insurance:_____ Policy #:_____

Group Number:_____ Subscriber Name:_____

Subscriber DOB:_____

Who may we contact in case of an emergency other than a parent/guardian:

Emergency Contact:_____ Relationship:_____ Phone:_____

Additional Persons to Consent for Medical Care

I give the named individuals listed below my full permission to seek medical care including but not limited to injections, laceration repair, prescriptions, general medical care and emergency medical care for my child as the situation warrants.

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Parent/Legal Guardian Signature:_____ Date: ____ / ____ / ____

Please Read, Sign and Date the Back Side of this sheet

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Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name:_____

I have received a copy of the Notice of Privacy Practice for the above named practice.

Parent/Guardian Signature:_____ Date: ____ / ____ / ____

Authorization of Treatment and Assignment of Benefit

I authorize Greenville Pediatric Services, Inc. to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Greenville Pediatric Services, Inc. for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian Signature: _____ Date: ____ / ____ / ____

Contact Methods

Greenville Pediatric Services, Inc. is allowed to leave voicemails with the telephone numbers on the patient demographics sheet regarding patient information:

Yes ☐ No ☐

For email communication, I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communications:

Yes ☐ No ☐

Parent/Guardian Signature: _____ Date: ____ / ____ / ____

FOR PATIENTS 16 YEARS AND OLDER ONLY

Patient listed above may present and be treated unaccompanied by an adult.

Yes ☐ No ☐

Parent/Guardian Signature: _____ Date: ____ / ____ / ____