



97 Cornerstone Drive ♦ Cary, NC ♦ 27519
Telephone: (919) 460-0993 ♦ Fax : (919) 481-3952

Patient Data 2010

Date: _____

Child's Name: _____ Date of Birth: _____
Mailing Address: _____ City: _____ Zip Code: _____
SS #: _____ Nickname: _____ Sex: M _____ F _____

Father's Full Name: _____ Date of Birth: _____ Phone #: _____
SS#: _____ Mailing Address (if different than child): _____ Zip Code: _____
Employer: _____ Phone #: _____ Email: _____
Insurance Coverage with this employer for child? Yes _____ No _____ Cell Phone#: _____
If Yes, Name of Insurance Company: _____

Mother's Full Name: _____ Date of Birth: _____ Phone #: _____
SS#: _____ Mailing Address (if different than child): _____ Zip Code: _____
Employer: _____ Phone #: _____ Email: _____
Insurance Coverage with this employer for child? Yes _____ No _____ Cell Phone#: _____
If Yes, Name of Insurance Company: _____

Other Insurance Coverage (Medicaid, NC Health Choice, etc.): _____

Emergency Contact # 1: _____ Relationship : _____ Phone #: _____
Emergency Contact # 2: _____ Relationship : _____ Phone #: _____

OTHER FAMILY MEMBERS WHO ARE PATIENTS AT CORNERSTONE PEDIATRIC AND ADOLESCENT MEDICINE:

Full Name : _____ DOB : _____
Full Name : _____ DOB : _____
Full Name : _____ DOB : _____

I give permission for Physicians of Cornerstone Pediatric and Adolescent Medicine, or persons designated by them, to interview, examine and perform necessary laboratory procedures and to provide appropriate treatment to the above named minor. Permission for evaluation and treatment granted whether child presented by parent, other family member, unrelated third party, or unaccompanied.

Signed: _____ Relationship: _____ Date: _____

I hereby authorize Cornerstone Pediatric and Adolescent Medicine, to furnish any necessary information concerning my child, _____ to my insurance carriers, to other personnel to whom physicians of Cornerstone Pediatric and Adolescent Medicine have referred my child for treatment, and to the admitting hospital should my child be admitted for treatment.

Signed: _____ Relationship: _____ Date: _____

I understand all professional charges are charged to the patient. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible or coinsurance at the time of service. Patients covered under non-contracted insurance plans are responsible for filling all office charges with the insurance carriers with the information we provide for that purpose. The patient is responsible for all fees regardless of insurance coverage. **NOTE: Divorce has no bearing on the responsibility for medical care as it affects third parties. Whoever brings the child is expected to pay the charges due for the service rendered that day.** Cornerstone Pediatric and Adolescent Medicine does not get involved in payment dispute between parents. I understand that insurance/Medicaid cards are required to be presented at every visit.

Signed: _____ Relationship: _____ Date: _____