ABC pediatrics
OF GREENSBORO, PA

1002 N. Church St., Suite 1 Greensboro, NC 27401
(336) 235-3060 (336) 235-3079 (fax)

➢ Patient Information:

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Date of Birth: _____ **Social Security #:** _____ **Sex:** **M** **F**

Street Address: _____ **City/State:** _____ **Zip Code:** _____

➢ Parent/ Guardian Information:

Guardian/Father's Name: _____ **Date of Birth:** _____ **SS #:** _____

Street Address: _____ **City/State:** _____ **Zip:** _____
(If different from patient)

Home Phone: _____ **Alternate Phone:** _____

Guardian/Mother's Name: _____ **Date of Birth:** _____ **SS #:** _____

Street Address: _____ **City/State:** _____ **Zip:** _____
(If different from patient)

Home Phone: _____ **Alternate Phone:** _____

➢ Please list ALL children (first name, last name, and date of birth) seen by our practice that are in your household

1. _____
2. _____
3. _____
4. _____
5. _____

➢ Insurance Information: PLEASE COMPLETELY FILL OUT THIS INFORMATION

Primary Insurance: _____ **Policy Holder:** _____

Subscriber #: _____ **Group #:** _____

Policy Holder's D.O.B: _____ **Policy Holder's Sex: M F**

Policy Holder's Social Security Number: _____

Secondary Insurance: _____ Policy Holder: _____

Subscriber #: _____ Group #: _____

Policy Holder's D.O.B: _____ Policy Holder's Sex: M F

Policy Holder's Social Security Number: _____

May we leave detailed messages on an answering machine? Yes No

(*Such as appointment reminders, lab or test results, or referral appointments)*

If yes what is the best number: _____

What is the primary Pharmacy for your family?

Pharmacy Name: _____ Pharmacy Street Address: _____

Telephone Number: _____

It is our goal here at ABC Pediatrics of Greensboro, P.A, to provide you with the highest quality of care. Keeping your scheduled appointment will help our office ensure that you receive the care that you deserve. Please note that insurance cannot be filed until ALL the insurance information is completed and a copy of your card is on file. Always bring your most recent card with you to appointments. Well child visits will be rescheduled for a more convenient time if the co-pay is not paid at time of service or if the insurance card is not presented. By signing below, I authorize and consent to the release of any medical and/or personal information related to my child (ren) that is necessary to process an insurance claim. I authorize the payment of insurance claims filed to be made to the physician/provider for services rendered. I have read the Privacy Notice for ABC Pediatrics of Greensboro, P.A. This authorization will remain in effect until revoked by me in writing.

_____ _____

Parent/Guardian Signature Date