Carolinas HealthCare System

Mecklenburg Medical Group

ORG# _____

MRN# _____

	Patient	***Parent/Responsible Party-*** *if different* **Patient Relationship** ☐ Child ☐ Spouse ☐ Other
Legal Last Name		
Legal First Name, Middle		
Nick Name		
SSN:		
Date of Birth		
Sex	☐ Male ☐ Female	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow	
Address		
Apt/Bldg/Suite #		
City, State, Zip		
Home Phone:		
Mobile Phone:		
Email Address:		
Employer Name		
Address		
City, State, Zip		
Phone		

Emergency Contact	**Reason for visit** _____
Name	
Home Phone	
Work Phone	Who referred you? _____
Mobile Phone	Permission to leave voice mail @ primary phone number? ☐ Yes ☐ No

	Primary Insurance	**Secondary Insurance**
Insurance Company		
Primary Policyholder Name		
Primary Policyholder DOB		
Primary Policyholder Sex	☐ Male ☐ Female	

Primary Care Physician		If none, do you need help finding a Primary Care Physician? ☐ Yes ☐ No

How did you learn about us? *(Check One)* ☐ Employer ☐ Insurance ☐ Yellow Pages ☐ Advertisement ☐ Family/Friend ☐ Other _____

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: _____