

PATIENT INFORMATION

Name (Last, First, Middle, Maiden)		Social Security Number		Birthdate		Sex	
Address (Street/PO Box)				City, State, Zip			
Race		Ethnicity		Language			
Primary Care Physician				Referring Physician			
Marital Status: Single Married Divorced Widowed		Employment Status: Full-time Part-time Student		Occupation			
Employer		Employer Address (Street/PO Box)		City, State, Zip			
Home Phone		Day Phone		Alternate Phone		Email Address	

LEGAL GUARDIAN OR POWER OF ATTORNEY (if other than patient)

Name (Last, First, Middle)		Social Security Number		Birthdate		Sex	
Address (Street/PO Box)				City, State, Zip			
Marital Status: Single Married Divorced Widowed		Employment Status: Full-time Part-time Student		Occupation			
Employer		Employer Address (Street/PO Box)		City, State, Zip			
Home Phone		Day Phone		Alternate Phone		Secondary Home Phone	

EMERGENCY CONTACT INFORMATION

Name		Relationship		Phone	
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Do you have UNC Charity Care Yes No

PRIMARY INSURANCE

Name of Insurance Company		Subscriber ID/Policy Number		Group Number	
Full Name of Insured		Insured's Social Security Number		Insured's Date of Birth	
Relationship to Patient		Insured's Employer			

SECONDARY INSURANCE (if applicable)

Name of Insurance Company		Subscriber ID/Policy Number		Group Number	
Full Name of Insured		Insured's Social Security Number		Insured's Date of Birth	
Relationship to Patient		Insured's Employer			

MEDICAID

Patient Name Exactly As It Appears On Medicaid Card

Medicaid ID Number

Effective Date

Name of Patient's Social Worker

Phone

Is patient enrolled in Carolina Access?
Yes No**I verify that the above information is correct.**

Patient/Guarantor Signature

Date