ABC Pediatrics of Asheville

64 Peachtree Road, Suite 100 Asheville, NC 28803
(828) 277-3000 Fax (828) 277-3636

Patient Registration Form

Please circle your child's primary physician

Peter Chu, MD Derek Dephouse, MD Robert Errico, MD Scott Love, MD Hope Mustoe, MD John Paschall, MD Laurie Pulver, MD Beth Vo, MD

*Please list all children on account

Last Name	First Name	Middle Initial	Gender	Birth Date	Race	Ethnicity

ETHINICITY: Hispanic (H) Non-Hispanic (NH) Refuse to report (R)
RACE: American Indian (AI) Alaska Native (AN) African American (AA) More than one Race (M)
Pacific Islander (PI) Caucasian (C) Asian (A) Refuse to report (R)
****Race and Ethnicity are required under new medical guidelines****

Preferred Language: English Spanish Russian Other_____
Preferred Method of Contact (circle ONE only) Text Email Cell Home Work
Parent Information: Married Single Separated Divorced Living Together

Mother's Information

Last Name_____ Home Tel #_____
First Name_____ Cell # _____
Address_____
City_____ State_____
Zip Code_____ SSN_____
DOB_____ Employer_____Phone_____
Email_____

Father's Information

Last Name_____ Home Tel#_____
First Name_____ Cell #_____
Address_____
City_____ State_____
Zip Code_____ SSN_____
DOB_____Employer_____Phone_____
Email_____

Primary Insurance Information (If other than Medicaid)

Policy Holder's Name_____ Relationship to patient_____
Policy Holder's Address_____
Policy Holder's Date of Birth_____ Social Security # _____
Insurance Company Name_____

Continued on back of page

Secondary Insurance Information (If applicable)
Policy Holder's Name_____ Relationship to patient _____
Policy Holder's Address_____
Policy Holder's Date of Birth_____ Social Security #_____
Insurance Company Name_____

(Please Provide a Copy of Insurance Card to the Receptionist at Every Visit)

Responsible Party Statement**:** I hereby authorize ABC Pediatrics to furnish information to insurance carriers concerning my child/children's illness and treatment. I understand that I am financially responsible for all charges whether or not covered by insurance.

Responsible Party Signature_____

Consent to Treat: I hereby authorize and request ABC Pediatrics to provide diagnostics and treatment.
I give the persons below permission to bring my child/children to be seen at ABC Pediatrics for diagnosis and treatment.
Name and Phone_____

Name and Phone_____

Signature:_____ **Date:**_____