R & R PEDIATRICS, PLLC

Location: HWY 55
3100 NC HWY 55 Ste# 202
Cary, NC 27519
Phone: (919) 367-9833; Fax: (919) 367-9832

Location: Carpenter Fire Station
7560 Carpenter Fire station Rd Ste#201
Cary, NC 27519
Phone: (919) 367-9834; Fax: (919) 367-9832

PLEASE COMPLETE ENTIRE FORM

Account/Chart #_____

Patient Last Name _____ First Name _____ Middle Name _____

DOB: _____ Sex: ☐Male ☐Female Social Security Number of Patient: _____

Race: ☐ American Indian and Alaska Native ☐Asian ☐Black or African American ☐Hispanic ☐Native Hawaiian and other Pacific Islander ☐White ☐Declined to specify

Ethnicity: ☐Declined to specify ☐Hispanic or Latino ☐Not Hispanic or Latino

Preferred Language: _____ Other Languages _____

Preferred Communication: ☐Mobile Phone ☐Home Phone ☐Work Phone ☐E-mail Any Call Restrictions? _____

Child Resides with Whom? ☐Both Parents ☐Mother ☐Father ☐Grand Parent ☐Legal Guardian ☐ Other _____

Mother: Last Name _____ First Name _____ DOB _____ SSN _____

Street Address _____ City _____ State _____ ZIP _____

Phone: Home _____ Work _____ Cell _____

Occupation _____Employer _____

Email* _____ Do you wish appointment reminders by e-mail? ☐ YES ☐ NO

Father: Last Name _____ First Name _____ DOB _____ SSN _____

☐Address same as Mother's

Street Address _____ City _____State _____ZIP _____

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____

Email* _____ Do you wish appointment reminders by e-mail? ☐ YES ☐ NO

Guardian (if any): Last Name _____ First Name: _____ DOB: _____ SSN _____

Street Address _____ City _____ State _____ ZIP _____

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____

Email* _____ Do you wish appointment reminders by e-mail? ☐ YES ☐ NO

Emergency Contact (not living in the same household):

Name _____ Relationship to patient _____ Phone _____

Name _____ Relationship to patient _____ Phone _____

Primary Insurance: Name _____ Address _____

Policy Holder _____ DOB _____ Relationship to patient _____

Policy Number (ID) _____ Group Number _____ Effective Date _____

Secondary Insurance: Name _____ Address _____

Policy Holder _____ DOB _____ Relationship to Patient _____

Policy Number (ID) _____ Group Number _____ Effective Date _____

Other family Members who are Patients to this Office:

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Date: _____ Signed by _____ Signature _____