

Triangle Pediatric Center, P.A.

101 SW Cary Parkway, Suite 270

Cary, NC 27511

Phone (919) 467-5543

Fax (919) 469-2391

[www.tripeds.com](http://www.tripeds.com)

Date: \_\_\_\_\_

Demographics

Please list all children in the family even if the child is not being seen today.

_____ (First)	_____ (Last)	_____ (DOB)	_____ (Nickname)	_____ (First)	_____ (Last)	_____ (DOB)	_____ (Nickname)
_____ (First)	_____ (Last)	_____ (DOB)	_____ (Nickname)	_____ (First)	_____ (Last)	_____ (DOB)	_____ (Nickname)

As a medical practice we may need to contact you regarding appointments, lab and X-ray results, etc so it is important that we have current information. Please remember to advise us of any changes to your phone numbers. Thank you.

Mother's Name _____	DOB _____	Father's Name _____	DOB _____
Address _____		Address _____	
City _____	State _____	Zip _____	
Home# _____	Cell# _____	Home# _____	Cell# _____
Employer _____	Work # _____	Employer _____	Work # _____
Email _____		Email _____	

Other Legal Guardian \_\_\_\_\_ DOB \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_

Who do children reside with? (circle one) Both Mother Father Other \_\_\_\_\_

If applicable, who has legal custody of the children? (circle one) Both Mother Father Other \_\_\_\_\_

What county do children reside in? (circle one) Wake Johnston Chatham Lee Other \_\_\_\_\_

Which phone # should we list as your primary contact? \_\_\_\_\_

Language Preference \_\_\_\_\_

Emergency Contact

Please provide us with the name of someone other than the parent or guardian in the event we are unable to contact you.

Name _____	Contact # _____	Relationship _____
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# TRIANGLE PEDIATRIC CENTER, P.A.

## FINANCIAL POLICY

We accept assignment on many insurance companies upon verification of benefits. If we are unable to verify coverage at the time of your visit, we request that you pay your bill in full. We accept cash, check, Visa and MasterCard.

YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. We are happy to assist you in any way to assure that you receive your benefits, but you are ultimately responsible for timely payment of your bill. If no payment has been received from your insurance company after 60 days, you will be billed for the remaining balance. If any check you issue to Triangle Pediatric Center, P.A. is returned for non-sufficient funds, you agree that your account will be debited electronically for both the face amount of the check and for returned check fees allowed under applicable law.

Uninsured patients or those filing their own insurance are expected to pay at the time care is provided. Again we accept cash, check, Visa and MasterCard. We do not wish to deny care to patients who are truly unable to pay. If you are having difficulty paying for your medical care, you must see our Office Manager before being seen by your medical provider.

Thank you for understanding the Financial Policy of Triangle Pediatrics Center, P.A.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date