Patient's Full Name:	Patient's Preferred Name:
Street Address	City, State and Zip Code

Date of Birth:	Gender: ☐-Male ☐-Female	County of Residence: ☐-Wake ☐-Durham ☐-Other:
Race: ☐-American Indian ☐-Alaska Native ☐-Asian ☐-Other Pacific Islander ☐-Hawaiian Native ☐-White ☐-African American ☐-Hispanic ☐-Other Race	Ethnicity: ☐-Hispanic or Latino ☐-Not Hispanic or Latino	Is your family comfortable communicating in English? ☐-Yes ☐-No, this is our preferred language (please list):

PARENTS

Mother's Name:		Father's Name:	
Mother's Address (☐-*same as listed above*):		Father's Address (☐-*same as listed above*):	
Mother's Employer:		Father's Employer:	
Mother's Social Security Number:	Mother's Date of Birth:	Father's Social Security Number:	Father's Date of Birth:

CONTACT NUMBERS & E-MAIL

Preferred Contact Phone Number:

☐☐☐ – ☐☐☐ – ☐☐☐☐

Above number belongs to: ☐-Patient ☐-Other / List Name:

☐-This is a mobile number:
RCAM may send a text message to the above number (minimal use – as with appointment reminders); ☐-Yes ☐-No

☐-This is a "land line" home phone:
RCAM may leave phone messages at this number; ☐-Yes ☐-No

Other Phone Number(s):	Phone type:	This phone number belongs to:
	☐-Mobile ☐-Home ☐-Work	☐-Patient ☐-Other / List Name:
	☐-Mobile ☐-Home ☐-Work	☐-Patient ☐-Other / List Name:
	☐-Mobile ☐-Home ☐-Work	☐-Patient ☐-Other / List Name:
	☐-Mobile ☐-Home ☐-Work	☐-Patient ☐-Other / List Name:

Preferred E-Mail:

This E-Mail belongs to: ☐-Patient; ☐-Other / List Name:

PREFERRED PHARMACY

Name of Pharmacy	Address	Phone

GUARANTOR

Guarantor's Name		Guarantor's Address (if different than already listed)
Guarantor's Social Security Number	Guarantor's Employer	

PRIMARY INSURANCE

Name of Primary Insurance Company			Effective Date
Policy Holder's Name		Relationship to Patient	Policy Holder's Date of Birth
ID Number	Group Number	Co-Pay	Deductible

Please list other children covered under this PRIMARY health insurance policy below:

SECONDARY INSURANCE

Name of Secondary Insurance Company			Effective Date
Policy Holder's Name		Relationship to Patient	Policy Holder's Date of Birth
ID Number	Group Number	Co-Pay	Deductible

Please list other children covered under this SECONDARY health insurance policy below:

If you are a new patient, where did you hear about our office?

☐ Friend ☐ Obstetrician ☐ Yellow Pages / yp.com ☐ Angie's List

☐ Internet Search ☐ Carolina Parent ☐ Facebook ☐ Other (please describe):

I verify all information above and that RCAM's Notice of Privacy Practices (HIPAA policy) has been made available to me

Signature Date