Dr. George M Wadie, MD, FACS, FAAP

600 New Waverly Place #203
Cary, NC 27518

Office: (919) 858-7020
Fax: (253) 859-5695
Carolinapediatricsurgery.com

Carolina Pediatric Surgery

NEW ADULT PATIENT INFORMATION

For Ofc Use:					**MR #:**

Patient Full Name (Last, First, MI)**:**

Address: **City:** **State:** **Zip:**	**Maiden/Other Name:** **Sex:** **Date of Birth:** **Age:** **Social Security #:**
Please check box for preferred communication: ❑ **Home #:** ❑ **Work #:** ❑ **Cell #:** ❑ **Email:**	Language: Ethnicity: ❑ Hispanic/Latino ❑ Unreported/Refused ❑ Not Hispanic/Not Latino
Employer: Address: City: State: Zip:	Race: ❑ American Indian/Alaskan ❑ Other Pac Islander ❑ Asian ❑ White ❑ Black/African American ❑ More than 1 Race ❑ Native Hawaiian ❑ Unreported/Refused
Emergency Contact: Home #: Cell #: Work #: Relationship:	**Preferred Pharmacy:** Phone #: City:
Referring Dr:	**PCP Name:**

Guarantor Information *(if different from patient)*:

Guarantor Name:	Relationship:
Address: **City:** **State:** **Zip:** **Home Phone#:** **Work Phone#:** **Cell Phone#:**	Date of Birth: Social Security #: Employer: Address: City: State: Zip:

Insurance Information

Primary Insurance Carrier:	**Secondary Insurance Carrier:**
Certificate/ID #:	**Certificate/ID #:**
Group Number:	**Group Number:**
Group Name:	Group Name:
Copay:	Copay:
Subscriber Information *(If Different From Patient)*	
Name:	Name:
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wake Pediatric Surgery or insurance company to release any information required to process my claims.

Patient/Resp. Party signature _____ **Print name** _____ **Date** _____