Chapel Hill Children & Adolescents' Clinic
301 Kildaire Rd, Suite 200
Chapel Hill, NC 27516
(919) 967-0771 Fax (919) 967-9207

EHR PATIENT
UPDATE FORM

□ ENTERED

WE HAVE SWITCHED TO ELECTRONIC HEALTH RECORDS, PLEASE COMPLETE THIS FORM TO ASSIST US IN UPDATING YOUR CHILD'S CHART. THANK YOU!

DATE: _____ FOR OFFICE USE:

PATIENT NAME: _____ PATIENT NUMBER

DATE OF BIRTH: _____

SIBLING(S): _____

_____

HOME PHONE: (_____)_____EMAIL ADDRESS: _____

PATIENT PHONE (if applicable): (_____)_____

STREET ADDRESS: _____ APT NO. _____

CITY: _____ STATE: _____ ZIP: _____

RACE: _____□ Decline PREFERRED LANGUAGE: _____

ETHNICITY: □ Hispanic/Latino □ Filipino □ Not Hispanic/Latino □ Decline

PARENTS/GUARDIANS:

NAME:	HOME PHONE:	CELL PHONE:	WORK PHONE:	SSN:
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	

INSURANCE COMPANY NAME: _____

POLICYHOLDERS NAME: _____ SSN: _____

EMERGENCY CONTACT INFORMATION: (NAME AND PHONE NUMBER OF NEAREST RELATIVE OR FRIEND OTHER THAN PARENT)

NAME: _____

PHONE: (_____)_____ RELATIONSHIP: _____

NOTICE OF PRIVACY PRACTICES OF CHAPEL HILL CHILDREN'S CLINIC:

PLEASE LET US KNOW IF YOU WOULD LIKE A NEW COPY OF OUR NOTICE OF PRIVACY PRACTICES (OTHER THAN THE ONE RECEIVED AT YOUR FIRST VISIT).

PRINT YOUR NAME: _____

YOUR SIGNATURE: _____ DATE: _____

ELECTRONIC COMMUNICATION:

PLEASE LET US KNOW IF YOU WISH TO **OPT OUT** OF RECEIVING ELECTRONIC COMMUNICATION FROM US. WE WILL NEVER SHARE YOUR EMAIL ADDRESS WITH ANYONE, FOR ANY REASON.