PATIENT INFORMATION

Child 1: First Name:_____ **Middle Name:**_____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Place of Birth: _____ **SSN:** _____ - _____ - _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name & Relationship):_____
Relationship to Mother/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other
Relationship to Father/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other

Child 2: First Name:_____ **Middle Name:**_____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Place of Birth: _____ **SSN:** _____ - _____ - _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name & Relationship):_____
Relationship to Mother/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other
Relationship to Father/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other

Child 3: First Name:_____ **Middle Name:**_____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Place of Birth: _____ **SSN:** _____ - _____ - _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name & Relationship):_____
Relationship to Mother/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other
Relationship to Father/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other

Child 4: First Name:_____ **Middle Name:**_____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Place of Birth: _____ **SSN:** _____ - _____ - _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name & Relationship):_____
Relationship to Mother/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other
Relationship to Father/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other

Child 5: First Name:_____ **Middle Name:**_____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Place of Birth: _____ **SSN:** _____ - _____ - _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name & Relationship):_____
Relationship to Mother/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other
Relationship to Father/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other

Child 6: First Name:_____ **Middle Name:**_____ **Last Name:**_____
DOB: _____ **Gender:** ☐ Male ☐ Female **Primary Language:** _____
Place of Birth: _____ **SSN:** _____ - _____ - _____
Ethnicity: Hispanic/Not Hispanic/Unknown **Race:** Am. Indian or Alaskan/Asian/Black/Hawaiian/White/Unknown
Child's Primary Address? Parents Mom Dad Other (Name & Relationship):_____
Relationship to Mother/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other
Relationship to Father/guardian listed below ☐ Biological Child ☐ Step Child ☐ Adoptive Child ☐ Foster Child ☐ Other

Preferred Pharmacy:_____ Pharmacy Location:_____

Insurance Information:

Primary Policy

Insurance Carrier:_____ Insurance ID#: _____ Group #:_____

Name of Policy Holder:_____ DOB of Policy Holder: _____

Secondary Policy

Insurance Carrier:_____ Insurance ID#: _____ Group #:_____

Name of Policy Holder:_____ DOB of Policy Holder: _____

Mother/Guardian Info

First Name:_____ **Middle Name:**_____ **Last Name**:_____ DOB:_____

Employer/Occupation:_____ **SSN:** _____

Primary Phone (Circle: Home/Cell) _____ **Secondary Phone (Circle: Home/Cell/Work)** _____

Home Address:_____

Email:_____ **Authorized to have access to patient's records electronically? ☐ YES ☐ NO**

What is your preferred method of contact for appointment reminders? Cell Phone/Home Phone/Email

Father/Guardian Info

First Name:_____ **Middle Name:**_____ **Last Name**:_____ DOB:_____

Employer/Occupation:_____ **SSN:** _____

Primary Phone (Circle: Home/Cell) _____ **Secondary Phone (Circle: Home/Cell/Work)** _____

Home Address:_____

Email:_____ **Authorized to have access to patient's records electronically? ☐ YES ☐ NO**

What is your preferred method of contact for appointment reminders? Cell Phone/Home Phone/Email

Responsible Party Information: The responsible party is the person that will be receiving the billing statements. This person is also financially responsible for the patient's medical bills. Copays and balance payment are expected at the time of service, regardless of custodial arrangements.

First Name: _____ Middle Name: _____ Last Name: _____ DOB: _____

Home Address: _____

Street City State Zip Code

Phone Number: _____ Relationship to Patient: _____

Notify In Case Of Emergency (Not A Parent/Guardian)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Separated/Divorced Families

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ☐ YES ☐ NO

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Authorized Parities (including parents): I acknowledge that as a pediatrician's office, there are other people that I will want to have access to my child/children's medical information in case I am not available or do not have the information they need. This section allows me to authorize these individuals with the right to my child's medical information. **If there are any individuals listed below who should only have limited access to the information, I must document that next to their name.** Otherwise, the individuals listed below can have full access to any of my child/children's medical information. I hereby authorize you to use or disclose protected health information to the following people who care

for my child/children and would need access to this information should I not be present at the time of a visit or during a phone conversation. I understand that any of the people listed below may be taken off this list by sending a written request to the Privacy Officer of the practice. I also understand that I may add people to this list my submitting a written request to the Privacy Officer. I also understand that any additions or removal from this list is the sole responsibility of the parent/guardian and not of the practice.

First Name: _____ Middle Name: _____ Last Name: _____ DOB: _____
Phone Number: _____ Relationship to Patient: _____

First Name: _____ Middle Name: _____ Last Name: _____ DOB: _____
Phone Number: _____ Relationship to Patient: _____

First Name: _____ Middle Name: _____ Last Name: _____ DOB: _____
Phone Number: _____ Relationship to Patient: _____

First Name: _____ Middle Name: _____ Last Name: _____ DOB: _____
Phone Number: _____ Relationship to Patient: _____

Authorization of Treatment and Assignment of Benefits

I authorize Children First Pediatrics of Virginia, P.C. to treat my child. I have been presented with a copy of the Notice of Privacy Practice detailing how my child's health information may be used and disclosed as permitted under the federal and state law and outlining my rights regarding my child's health information. I also acknowledge that I have been presented with a copy of Children First Pediatrics of Virginia, P.C. Office Policies outlining all aspects of our practice including, but not limited to, our Financial, No Show and our Late Arrival policies.

Signature of Parent or Legal Guardian: _____

Relationship to Patient _____ Date: _____

Person Completing Form

Printed Name:_____ Signature: _____ Date: _____