- ❑ Annual ____________
- ❑ Change of Address
- ❑ Change of Insurance
- ❑ New Patient

VIRGINIA PEDIATRIC GROUP, LTD

PLEASE PRINT CLEARLY AND COMPLETE ALL BLANKS

Child's Full Name: ______________________________ DOB: ____________

Sex: ____________________ Nickname: ______________________________

Ethnicity: ____________________ (Hispanic, Non-Hispanic Unreported) Race: ____________________ (American Indian, Pacific Islander, Asian, African American, White, Unreported)

Language Spoken: ____________ Interpreter needed: ____________ Special communication needs: ____________

Which provider do you prefer to see? 1. ____________ 2. ____________ 3. ____________

Child's Full Name: ______________________________ DOB: ____________

Sex: ____________________ Nickname: ______________________________

Ethnicity: ____________________ (Hispanic, Non-Hispanic Unreported) Race: ____________________ (American Indian, Pacific Islander, Asian, African American, White, Unreported)

Language Spoken: ____________ Interpreter needed: ____________ Special communication needs: ____________

Which provider do you prefer to see? 1. ____________ 2. ____________ 3. ____________

Child's Full Name: ______________________________ DOB: ____________

Sex: ____________________ Nickname: ______________________________

Ethnicity: ____________________ (Hispanic, Non-Hispanic Unreported) Race: ____________________ (American Indian, Pacific Islander, Asian, African American, White, Unreported)

Language Spoken: ____________ Interpreter needed: ____________ Special communication needs: ____________

Which provider do you prefer to see? 1. ____________ 2. ____________ 3. ____________

If parents are separated, with whom do the children reside: ____________________ Primary caregiver: ____________________

Father's Full Name: ______________________________ DOB: ____________ SSN: ____________

Home Address: ______________________________ City: ____________ State: ______ Zip: ____________

Occupation: ____________________ Employer: ____________________ Email: ____________________

Work Address: ______________________________ City: ____________ State: ______ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

Mother's Full Name: ______________________________ DOB: ____________ SSN: ____________

Home Address: ______________________________ City: ____________ State: ______ Zip: ____________

Occupation: ____________________ Employer: ____________________ Email: ____________________

Work Address: ______________________________ City: ____________ State: ______ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

IN CASE OF EMERGENCY, NOTIFY: ______________________________ **PHONE:** ____________________

Child's Full Name: _____ DOB: _____

Preferred Pharmacy Name: _____ **Address:** _____

City _____ **State** _____ **Zip** _____

Phone # _____ **Fax #** _____

PRIMARY INSURANCE INFORMATION:

Company: _____ Effective Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Policyholders Name: _____ DOB: _____

Policy or ID #: _____ Group #: _____ Phone: _____

SECONDARY INSURANCE INFORMATION: (if applicable)

Company: _____ Effective Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Policyholders Name: _____ DOB: _____

Policy or ID #: _____ Group #: _____ Phone: _____

ADDITIONAL PARENT INFORMATION:

Full Name: _____ DOB: _____ SSN: _____ Relation to patient: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Email: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Full Name: _____ DOB: _____ SSN: _____ Relation to patient: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Email: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

The patient is responsible for knowing the specifics of his/her insurance plan and following its procedures. We strongly advise checking with your insurance carrier prior to visiting a Specialty Doctor, obtaining X-rays, hospital admissions and any such outside services. The patient is responsible for communicating any of the above mentioned special needs to the office staff and is ultimately responsible for payment for any services rendered. Payment is requested at the time of the service unless prior other arrangements have been made. VPG will not be responsible for any fees incurred for these services.

Please sign below signifying that you have read and understand the above statement and that this office has permission to submit insurance claims on your behalf and has permission to release any information, including medical, to the above carrier when a written request has been received by VPG. This office is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer or employer.

SIGNATURE: _____ DATE: _____