

VIRGINIA PEDIATRIC GROUP, LTD.

PLEASE PRINT CLEARLY AND COMPLETE ALL BLANKS

CHILDREN'S FULL LEGAL NAME (FIRST MIDDLE LAST)	SEX	BIRTH DATE	CHILD'S NICKNAME	DRUG ALLERGIES
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				

IF PARENTS ARE SEPARATED – WITH WHOM DOES CHILD RESIDE? _____

FATHER'S FULL NAME: _____ SS#: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

OCCUPATION: _____ EMPLOYER: _____

WORK ADDRESS: _____ PHONE: _____

EMAIL ADDRESS: _____

MOTHER'S FULL NAME: _____ SS#: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

OCCUPATION: _____ EMPLOYER: _____

WORK ADDRESS: _____ PHONE: _____

EMAIL ADDRESS: _____

PRIMARY INSURANCE COMPANY: _____ **EFFECTIVE DATE:** _____

POLICY OR ID #: _____ **GROUP OR PLAN #:** _____

SUBSCRIBER or POLICYHOLDER NAME: _____ **BIRTH DATE:** _____

MEMBER SERVICES TELEPHONE #: _____

IN EMERGENCY, NOTIFY: _____ PHONE #: _____

REFERRED TO OUR OFFICE BY: _____

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 of any services rendered. Payment is requested at the time of service unless other arrangements have been made. The ancillary specialists at Virginia Pediatric Group (VPG) are important members of our clinical and therapeutic team. We have developed effective working relationships and treatment regimens with each of them. They are independent contractors and are paid separately for each service performed. Many of their services are covered by insurance plans; however, the responsibility for payment remains with the patient. 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: _____