PediatriCare of Northern Virginia

REGISTRATION INFORMATION – PLEASE PRINT LEGIBLY

Legal Last Name	Legal First Name	Middle Initial	Mother's Maiden Name	
Nick Name (Preferred Name)	**Gender** □ Male □ Female		**Date of Birth**	**SSN**
Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Decline			**Preferred Language** □ English □ Spanish □ Other	
Race □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White □ Prefer not to answer				

List Additional Siblings

Legal Last Name	Legal First Name	Middle Initial	Mother's Maiden Name	
Nick Name (Preferred Name)	**Gender** □ Male □ Female		**Date of Birth**	**SSN**
Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Decline			**Preferred Language** □ English □ Spanish □ Other	
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Parents/Legal Guardian Information

□ Mother □ Stepmother □ Legal Guardian

Full Name		Date of Birth	SSN
Home Address		City	State/Zip
Home Phone	Cell Phone	Email	

□ Father □ Stepfather □ Legal Guardian

Full Name		Date of Birth	SSN
Home Address		City	State/Zip
Home Phone	Cell Phone	Email	

Additional Parental Information

Does the patient live with both biological parents? □ Yes □ No

If no, what is the patient's current living situation?

□ Single-Parent Custody □ Joint Custody □ Foster Care □ Adoptive Family □ Other Family Members:_____

If the patient resides in more than one residence, we are required to know who has legal authority to authorize healthcare services for the patient.

Patient Initials: _____

Emergency Contact Person* (Someone other than Parents)

Name	Relation to Patient	Phone	Do they have permission to bring the child(ren) in?
			□ Yes □ No
Name	Relation to Patient	Phone	
			□ Yes □ No

Insurance/Billing Information

Primary Insurance Company Name		Member Services Phone # Patient Initials: _____
Name of Subscriber	Subscriber's DOB	Subscriber SSN
Policy ID#		Group #

Name of the Guarantor (Who the bills are sent to)
Billing Address
How would you like to receive billing statements? □ Billing Address □ Email _____

Communication Consent and Preference

Contact Name	□ Phone _____ □ Text _____ □ Patient Portal □ Email _____
Contact Name	□ Phone _____ □ Text _____ □ Patient Portal □ Email _____

CONSENT FOR TREATMENT

I, _____, parent or legal guardian of above listed patients, give consent to any medical care including but not limited to preventative care, urgent sick care, immunization, and emergency care to PediatriCare of Northern Virginia, P.C. for today and future visits.

Signature _____ Relationship _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION TO APPLICABLE PARTIES/ASSIGNMENT OF BENEFITS

I hereby authorize this physician/clinic to furnish any information required concerning the examination or treatment of the above listed patient(s). I further expressly agree and acknowledge that my signature on this document authorizes this physician/clinic to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted. I hereby authorize payment directly to the business office of this physician's clinic for medical benefits that may be otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by my insurance. In the event my account is referred to collections, I agree to pay all costs and expenses including all fees related to the collection thereof.

Signature _____ Relationship _____ Date _____

Patient Initials: _____