



## Pediatric Partners of Virginia - Family Registration Form

<b>CHILDREN'S INFORMATION</b> - PLEASE LIST ALL CHILDREN TO BE REGISTERED UNDER THIS ACCOUNT					
Legal Last Name	Legal First Name	Middle Name	Nickname	Date of Birth	Sex at Birth
1.					<input type="checkbox"/> M <input type="checkbox"/> F
<b>Ethnicity:</b> <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to Specify			<b>Race(s):</b> <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Declined to Specify <input type="checkbox"/> Other Race		
2.					<input type="checkbox"/> M <input type="checkbox"/> F
<b>Ethnicity:</b> <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to Specify			<b>Race(s):</b> <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Declined to Specify <input type="checkbox"/> Other Race		
3.					<input type="checkbox"/> M <input type="checkbox"/> F
<b>Ethnicity:</b> <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to Specify			<b>Race(s):</b> <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Declined to Specify <input type="checkbox"/> Other Race		
4.					<input type="checkbox"/> M <input type="checkbox"/> F
<b>Ethnicity:</b> <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to Specify			<b>Race(s):</b> <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Declined to Specify <input type="checkbox"/> Other Race		
Address where children reside: _____ City: _____ State: _____ Zip: _____ Primary Family Email: _____ Primary Family Phone: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Alternative: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home I prefer to be reminded of future appointments by <input type="checkbox"/> Home Phone, <input type="checkbox"/> Cell Phone, <input type="checkbox"/> Text Message.					
<b>Biological Parent/Legal Guardian Name:</b> _____ <b>Date of Birth:</b> _____ <b>Mobile Number:</b> _____ <b>Work Phone:</b> _____ Home Address (if different from child): _____ <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other: _____ City: _____ State: _____ Zip: _____ Employer: _____ <b>List as account guarantor?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Biological Parent/Legal Guardian Name:</b> _____ <b>Date of Birth:</b> _____ <b>Mobile Number:</b> _____ <b>Work Phone:</b> _____ Home Address (if different from child): _____ <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other: _____ City: _____ State: _____ Zip: _____ Employer: _____ <b>List as account guarantor?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center; font-size: small;">Please provide all legal guardianship or custody documents at the time of service.            Please list stepparents under the "Disclosures" section if you wish to include them in your child's care.</p>					
<b>Alternate/Emergency Contact (Other than Parent):</b> _____ Alternate Contact Phone: _____ Relationship to patient(s): _____ <p style="text-align: center; font-size: small;">Please list under the "Disclosures" section if we have permission to speak with them regarding your child's care.</p>					
PREFERRED PHARMACY					
Location: _____ Phone: _____					

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD.

Revised 03.2026



**INSURANCE INFORMATION – YOU MUST HAVE YOUR INSURANCE CARD FOR OUR RECEPTIONIST**

**Primary Insurance:** \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Policy Holder/Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Policy Holder/Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS/ CONSENT TO TREAT/ PRIVACY POLICY**

I understand that I am financially responsible for all professional charges that my children may incur. All copayments and non-covered charges are due at the time of service. All costs not paid by insurance are due upon receipt of the statement.

In accordance with Virginia law, any patient whose body fluids a healthcare worker has been exposed to have consented to HIV/HEPATITIS B & C TESTING. In all other cases, the patient shall have the right to be informed of consent or refusal for HIV/HEPATITIS B & C TESTING. We do not randomly test for HIV.

I hereby authorize the payment of medical benefits directly to Pediatric Partners of Virginia. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations. Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted; I give my permission to treat my child in their office as required by the events of an emergency.

Acknowledgment of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of the HIPAA Notice of Privacy Practices for Pediatric Partners of Virginia. A copy of the Privacy Policy can be found on our website at [www.ppvkids.com](http://www.ppvkids.com).

\_\_\_\_\_  
Parent/Guardian Signature (Patient Signature if 18 or older)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**.OPTIONAL: AUTHORIZATION FOR TREATMENT WHEN PARENT/GUARDIAN IS NOT PRESENT WITH CHILD (i.e., Nanny, Grandparent, Stepparent, and/or teen by themselves)**

I, \_\_\_\_\_, hereby consent to Pediatric Partners of Virginia and its Providers and Staff to examine and/or treat my child in my absence. I affirm that I have the legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/or treatments. I give the Providers and Staff permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate. I understand that I will be contacted for verbal consent if the treatment plan includes vaccines.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**OPTIONAL: DISCLOSURES TO FAMILY / FRIENDS (not including daycare, schools, camps)**

Please list all persons (Grandparent, babysitter, friend, etc.) who may receive health information regarding my child(ren), such as but not limited to scheduling, medical advice, treatment, prescriptions, medical forms, medical records, and billing information. These individuals may be asked to present identification. If someone other than those you listed below contacts us regarding your child, we will contact you for permission to advise or treat. In the event of an emergency, we will treat and make every possible attempt to contact you.

NAME                      RELATIONSHIP                      PHONE Number                      Restrictions (if any)

\_\_\_\_\_  
\_\_\_\_\_  
This authorization will remain in effect until further written notice by the patient/legal representative to discontinue. I understand that once information is released, it may be subject to redisclosure by the party receiving it and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date