Pediatric Partners of Virginia — Family Registration Form

CHILDREN'S INFORMATION - PLEASE LIST ALL CHILDREN TO BE REGISTERED UNDER THIS ACCOUNT

Legal Last Name	Legal First Name	Middle Name	Nickname	Date of Birth	Sex
1.					☐ M ☐ F
2.					☐ M ☐ F
3.					☐ M ☐ F
4.					☐ M ☐ F

Address where children reside: _____
City: _____ State: _____ Zip: _____
Preferred Pharmacy Location: _____ Phone: _____

Primary Family Email: _____ **Primary Family Phone:** _____

Parent/Guardian Name: _____ **Date of Birth:** _____
Mobile Number: _____ **Work Phone:** _____
Home Address (if different from child): _____
☐ Father ☐ Mother ☐ Other: _____ City: _____ State: _____ Zip: _____
Employer: _____ **List as account guarantor? ☐ Yes ☐ No**

Parent/Guardian Name: _____ **Date of Birth:** _____
Mobile Number: _____ **Work Phone:** _____
Home Address (if different from child): _____
☐ Father ☐ Mother ☐ Other: _____ City: _____ State: _____ Zip: _____
Employer: _____ **List as account guarantor? ☐ Yes ☐ No**

Alternate/Emergency Contact (Other than Parent): _____
Alternate Contact Phone: _____ Relationship to patient(s): _____

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 time of service. All costs not paid by insurance are due upon receipt of statement.

I hereby authorize payment of medical benefits direct 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.
Acknowledgement of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy Practices for Pediatric Partners of Virginia.

_____ _____ _____
Parent/Guardian Signature (Patient Signature if 18 or older) Printed Name Date